

MISCELLANEOUS MEDICARE AMENDMENTS ACT OF 1992

OCTOBER 8, 1992.—Ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce,
submitted the following

REPORT

[To accompany H.R. 5748 which on July 31, 1992, was referred jointly to the
Committee on Ways and Means and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 5748) to amend title XVIII of the Social Security Act to make miscellaneous amendments to the medicare program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Miscellaneous Medicare Amendments Act of 1992”.

(b) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Section. 1. Short title; table of contents.

TITLE I—PROVISIONS RELATING TO PART B

Subtitle A—Payment for Physicians' Services

- Sec. 101. Permitting separate payment for interpretation of electrocardiograms.
- Sec. 102. Payments for new physicians.
- Sec. 103. Anesthesia time.
- Sec. 104. Enforcement and application of extra-billing limits.
- Sec. 105. Requiring consultation with representatives of physicians in reviewing geographic adjustment factors.
- Sec. 106. Use of most recent data in geographic adjustment.
- Sec. 107. Administration of claims relating to physicians' services.
- Sec. 108. Study of services of medical physicists.
- Sec. 109. Study of adjustments to fee schedules to take into account practice-related taxes.
- Sec. 110. PHYSPRC study of radiology services.

Subtitle B—Payment for Other Items and Services

- Sec. 111. Distribution of certificates of medical necessity by suppliers of durable medical equipment.
- Sec. 112. Treatment of nebulizers and aspirators as miscellaneous items of durable medical equipment.
- Sec. 113. 2-year extension of payment limit on intraocular lenses.
- Sec. 114. Treatment of certain Indian health programs and facilities as Federally-qualified health centers.
- Sec. 115. Extension of medicare influenza vaccination demonstration project until April 1993.

TITLE II—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Miscellaneous Provisions

- Sec. 201. Revision of payments for graduate medical education to promote primary care services.
- Sec. 202. No medicare secondary payor denial based on failure to complete questionnaire.
- Sec. 203. Adjustment in medicare capitation payments to account for regional variations in application of secondary payor provisions.
- Sec. 204. Repeal of PRO precertification requirement for certain surgical procedures.
- Sec. 205. Improved outreach for qualified medicare beneficiaries.
- Sec. 206. Demonstration project regarding furnishing of durable medical equipment by physician-owned oncology facility.

Subtitle B—Provisions Relating to Medicare Supplemental Insurance Policies

- Sec. 211. Standards for medicare supplemental insurance policies.

TITLE I—PROVISIONS RELATING TO PART B

Subtitle A—Payment for Physicians' Services

SEC. 101. PERMITTING SEPARATE PAYMENT FOR INTERPRETATION OF ELECTROCARDIOGRAMS.

(a) IN GENERAL.—Paragraph (3) of section 1848(b) of the Social Security Act (42 U.S.C. 1395w-4(b)) is amended to read as follows:

“(3) TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.—The Secretary—

“(A) shall make separate payment under this section for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and

“(B) shall adjust the relative values established for visits and consultations under subsection (c) so as not to include relative value units for interpretations of electrocardiograms in the relative value for visits and consultations.”

(b) ASSURING BUDGET NEUTRALITY.—Section 1848(c)(2) of such Act (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraph:

“(E) BUDGET NEUTRALITY ADJUSTMENTS.—The Secretary—

“(i) shall reduce the relative values for all services established under this paragraph by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendments made by section 101(a) of the Miscellaneous Medicare Amendments Act of 1992 would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendments had not been made, and

“(ii) shall reduce the amounts determined under subsection (a)(2)(B)(i)(I) by such percentage as the Secretary determines to be required to assure that, taking into account the reduction in relative values made under clause (i), the amendments made by section 101(a) of the Miscellaneous Medicare Amendments Act of 1992 would not result in expenditures under this section in 1993 that exceed the amount of such expenditures that would have been made if such amendments had not been made.”

(c) **CONFORMING AMENDMENTS.**—Section 1848 of such Act (42 U.S.C. 1395w-4) is amended—

(1) in subsection (a)(2)(B)(i)(I), by inserting “and as required under subsection (c)(2)(E)(ii)” after “for 1993”;

(2) in subsection (c)(2)(A)(i), by adding at the end the following: “Such relative values are subject to adjustment under subparagraph (E)(i).”; and

(3) in subsection (i)(1)(B), by adding at the end “including adjustments under subsection (c)(2)(E).”

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after January 1, 1993.

SEC. 102. PAYMENTS FOR NEW PHYSICIANS.

(a) **EQUAL TREATMENT OF NEW PHYSICIANS AND PRACTITIONERS.**—(1) Section 1848(a) of the Social Security Act (42 U.S.C. 1395w-4(a)) is amended by striking paragraph (4).

(2) Section 1842(b)(4) of such Act (42 U.S.C. 1395u(b)(4)) is amended by striking subparagraph (F).

(b) **ENSURING BUDGET-NEUTRALITY.**—

(1) **PAYMENTS UNDER FEE SCHEDULES.**—Section 1848(c)(2)(E) of the Social Security Act, as added by section 101(b), is amended by striking “section 101(a)” each place it appears and inserting “section 101(a) and section 102(a)(1)”.

(2) **PAYMENTS FOR OTHER PRACTITIONERS.**—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall reduce the prevailing charges or fee schedule amounts for 1993, to be applied under section 1842(b) of the Social Security Act for that year and subsequent years, for professional services of a health care practitioner (as defined in section 1842(b)(4)(F)(ii)(I) of such Act, as in effect before the date of the enactment of this Act) by such percentage as the Secretary determines will result in a reduction in expenditures under part B of title XVIII of such Act for 1993 equivalent to the increase in expenditures under such part in the year attributable to the amendment made by subsection (a)(2).

(c) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 1993.

SEC. 103. ANESTHESIA TIME.

The Secretary of Health and Human Services may not change the payment methodology established under part B of title XVIII of the Social Security Act for anesthesia services insofar as such methodology provides for the use of actual time units in determining payments for anesthesia services.

SEC. 104. ENFORCEMENT AND APPLICATION OF EXTRA-BILLING LIMITS.

(a) **ENFORCEMENT.**—Paragraph (1) of section 1848(g) of the Social Security Act (42 U.S.C. 1395w-4(g)) is amended to read as follows:

“(1) **LIMITATION ON ACTUAL CHARGES FOR UNASSIGNED CLAIMS.**—

“(A) **NO BILLING IN EXCESS OF LIMITING CHARGES.**—A nonparticipating physician may not bill for physicians’ services furnished with respect to an individual enrolled under this part an actual charge in excess of the limiting charge described in paragraph (2) on a claim for which payment is not made on an assignment-related basis under this part.

“(B) **NO LIABILITY FOR EXCESS CHARGES.**—In the case of physicians’ services furnished with respect to an individual enrolled under this part and for which payment is not made on an assignment-related basis under this part, no person is liable for payment of any amounts billed in excess of the limiting charge described in paragraph (2).

“(C) **REFUND OF EXCESS CHARGES.**—If a physician bills and collects amounts in excess of the amounts permitted to be billed and collected under this paragraph, the physician shall provide the individual charged (not later than 30 days after the date the physician is notified under this part of such excess charges) with a refund (or, at the election of the individual, a reduction of any outstanding balance owed by the individual to the physician) in the amount of the excess charges.

“(D) **SANCTIONS.**—If a physician knowingly and willfully bills for services in violation of subparagraph (A) on a repeated basis or fails to comply with subparagraph (C), the Secretary may apply sanctions against the physician in accordance with section 1842(j)(2). In applying this subparagraph, paragraphs (3) and (4) of section 1842(j) shall apply in the same manner as such paragraphs apply to such section.”

(b) APPLICATION OF EXTRA-BILLING LIMITS TO PHYSICIANS' SERVICES FURNISHED BY ANY PERSON.—

(1) IN GENERAL.—Section 1848(g) of the Social Security Act (42 U.S.C. 1395w-4(g)) is amended—

(A) in paragraph (1), as amended by subsection (a) of this section—

(i) in subparagraph (A), by inserting “or nonparticipating supplier or other person (as defined in section 1842(i)(2))” after “nonparticipating physician”,

(ii) in subparagraph (C), by inserting “, supplier, or other person” after “physician” each place it appears, and

(iii) in subparagraph (D), by inserting “, supplier, or other person” after “physician” each place it appears and by inserting before the period at the end the following: “and any reference in paragraphs (2), (3), and (4) of such section to a physician is deemed to include a reference to a supplier or other person under this subparagraph”; and

(B) in paragraph (2)(C), by inserting “or for nonparticipating suppliers or other persons” after “nonparticipating physicians”.

(2) CONFORMING DEFINITION.—Section 1842(i)(2) of such Act (42 U.S.C. 1395u(i)(2)) is amended—

(A) by striking “, and the term” and inserting “; the term”, and

(B) by inserting before the period at the end the following: “; and the term ‘nonparticipating supplier or other person’ means a supplier or other person (excluding a provider of services) that is not a participating physician or supplier (as defined in subsection (h)(1))”.

(3) ADDITIONAL CONFORMING AMENDMENTS.—Section 1848 of such Act (42 U.S.C. 1395w-4) is amended—

(A) in subsection (a)(3), by inserting “AND SUPPLIERS” after “PHYSICIANS”, and by inserting “or a nonparticipating supplier or other person” after “nonparticipating physician”, and

(B) in subsection (j)(3), by inserting “, except for purposes of subsection (g),” after “tests and”.

(c) CLARIFICATION OF MANDATORY ASSIGNMENT RULES FOR CERTAIN PRACTITIONERS.—

(1) IN GENERAL.—Section 1842(b) of such Act (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

“(19)(A) Payment for any service furnished by a practitioner described in subparagraph (C) and for which payment may be made under this part under section 1833(a)(1) may only be made under this part on an assignment-related basis.

“(B) Except for deductible and coinsurance amounts applicable under this part, a practitioner described in subparagraph (C) may not bill the individual or other person for any service described in subparagraph (A). No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a practitioner knowingly and willfully bills for such a service in violation of such sentence, the Secretary may apply sanctions against the practitioner in the same manner as the Secretary may apply sanctions against a physician in accordance with section 1842(j)(2) in the same manner as such section applies with respect to a physician. Paragraphs (3) and (4) of section 1842(j) shall apply in this subparagraph in the same manner as such paragraphs apply to such section.

“(C) A practitioner described in this subparagraph is any of the following:

“(i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)).

“(ii) A certified registered nurse anesthetist (as defined in section 1861(bb)(2)).

“(iii) A certified nurse-midwife (as defined in section 1861(gg)(2)).

“(iv) A clinical social worker (as defined in section 1861(hh)(1)).

“(v) A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)).

“(D) For purposes of this paragraph, a service furnished by a practitioner described in subparagraph (C) includes any services and supplies furnished as incident to the service as would otherwise be covered under this part if furnished by a physician or as incident to a physician's service.”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1833 of such Act (42 U.S.C. 1395l) is amended—

(i) by amending subparagraph (B) of subsection (1)(5) to read as follows:

“(B) Any assignment agreed to by a certified registered nurse anesthetist with respect to services described in section 1842(b)(19) furnished by the anesthetist shall be

binding upon any other person presenting a claim or request for payment for services.", and

(ii) by striking subsection (p).

(B) Section 1842(b)(12) of such Act (42 U.S.C. 1395u(b)(12)) is amended by striking subparagraph (C).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1993.

SEC. 105. REQUIRING CONSULTATION WITH REPRESENTATIVES OF PHYSICIANS IN REVIEWING GEOGRAPHIC ADJUSTMENT FACTORS.

(a) IN GENERAL.—Section 1848(e)(1)(C) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(C)) is amended by striking "shall review" and inserting "shall, in consultation with appropriate representatives of physicians, review".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to physicians' services furnished on or after January 1, 1993.

SEC. 106. USE OF MOST RECENT DATA IN GEOGRAPHIC ADJUSTMENT.

(a) IN GENERAL.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)) is amended by adding at the end the following new subparagraph:

"(D) USE OF RECENT DATA.—In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect January 1, 1993.

SEC. 107. ADMINISTRATION OF CLAIMS RELATING TO PHYSICIANS' SERVICES.

(a) LIMITATION ON CARRIER USER FEES.—Section 1842(c) of the Social Security Act (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(A) Neither a carrier nor the Secretary may impose a fee under this title—

"(A) for the filing of claims related to physicians' services,

"(B) for an error in filing a claim relating to physicians' services or for such a claim which is denied,

"(C) for any appeal under this title with respect to physicians' services,

"(D) for applying for (or obtaining) a unique identifier under subsection (r), or

"(E) for responding to inquiries respecting physicians' services or for providing information with respect to medical review of such services."

(b) CLARIFICATION OF PERMISSIBLE SUBSTITUTE BILLING ARRANGEMENTS.—

(1) IN GENERAL.—Clause (D) of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)) is amended to read as follows: "(D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this clause for payment to the first physician".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act.

SEC. 108. STUDY OF SERVICES OF MEDICAL PHYSICISTS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the extent to which payment is made under part B of the medicare program for physicians' services that are furnished by medical physicists, and shall include in the study an analysis of the circumstances under which the furnishing of such services by medical physicists is medically appropriate.

(b) REPORT.—Not later than July 1, 1993, the Secretary shall submit a report to Congress on the study conducted under subsection (a), and shall include in the report the Secretary's recommendations regarding the appropriate method of payment under part B of the medicare program for physicians' services that are furnished by medical physicists.

SEC. 109. STUDY OF ADJUSTMENTS TO FEE SCHEDULES TO TAKE INTO ACCOUNT PRACTICE-RELATED TAXES.

(a) **STUDY.**—The Secretary of Health and Human Services shall conduct a study of the feasibility and desirability of adjusting the fee schedules for physicians' services established under section 1848 of the Social Security Act to take into account amounts paid by physicians for State and local taxes the imposition of which is directly related to the provision of physicians' services.

(b) **REPORT.**—Not later than July 1, 1993, the Secretary shall submit a report to Congress on the study conducted under subsection (a).

SEC. 110. PHYSRC STUDY OF RADIOLOGY SERVICES.

(a) **IN GENERAL.**—The Physician Payment Review Commission shall conduct a study of physician responses to changes in payments under the fee schedules under sections 1834(b) and 1848 of the Social Security Act. The study shall include an analysis of responses by specialty and category of services, including an analysis of differing responses among different specialties performing the same services.

(b) **REPORT.**—The Commission shall include a report on the study under subsection (a), including any appropriate recommendations, in its annual report to Congress under section 1845(b) of the Social Security Act.

Subtitle B—Payment for Other Items and Services

SEC. 111. DISTRIBUTION OF CERTIFICATES OF MEDICAL NECESSITY BY SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.

(a) **REQUIREMENTS FOR CERTIFICATES OF MEDICAL NECESSITY.**—Section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) is amended—

(1) in subparagraph (A), by striking "A supplier" and inserting "Except as provided in subparagraph (B), a supplier";

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following new subparagraph:

"(B) **EXCEPTION FOR CERTAIN BILLING INFORMATION.**—Subparagraph (A) shall not apply with respect to a form or document to the extent that the form or document contains information on the name and address of the patient to whom a covered item is furnished, a description of the item, and any product code identifying the item."

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect as if included in the enactment of section 4152(f)(1) of the Omnibus Budget Reconciliation Act of 1990.

SEC. 112. TREATMENT OF NEBULIZERS AND ASPIRATORS AS MISCELLANEOUS ITEMS OF DURABLE MEDICAL EQUIPMENT.

(a) **IN GENERAL.**—Section 1834(a)(3)(A) of the Social Security Act (42 U.S.C. 1395m(a)(3)(A)) is amended by striking "ventilators, aspirators, IPPB machines, and nebulizers" and inserting "ventilators and IPPB machines".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to items furnished on or after January 1, 1993.

SEC. 113. 2-YEAR EXTENSION OF PAYMENT LIMIT ON INTRAOCULAR LENSES.

Section 4151(c)(3) of the Omnibus Budget Reconciliation Act of 1990 is amended by striking "December 31, 1992," and inserting "December 31, 1994,".

SEC. 114. TREATMENT OF CERTAIN INDIAN HEALTH PROGRAMS AND FACILITIES AS FEDERALLY-QUALIFIED HEALTH CENTERS.

(a) **IN GENERAL.**—Section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)) is amended—

(1) by striking "or" at the end of subparagraph (B);

(2) by striking the period at the end of subparagraph (C) and inserting "; or"; and

(3) by adding at the end the following new subparagraph:

"(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act."

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect as if included in the enactment of section 4161(a)(2)(C) of the Omnibus Budget Reconciliation Act of 1990.

SEC. 115. EXTENSION OF MEDICARE INFLUENZA VACCINATION DEMONSTRATION PROJECT UNTIL APRIL 1993.

(a) **IN GENERAL.**—Section 4071(b)(1) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking the period at the end and inserting the following: “, except that the reference in clause (ii) of paragraph (2)(B) of such subsection to ‘24 months’ shall be deemed to be a reference to ‘30 months’.”.

(b) **LIMITATION ON USE OF AMOUNTS.**—The second sentence of section 4071(b)(2) of such Act is amended by striking “and evaluate” and inserting “and (during fiscal years other than fiscal year 1993) evaluate”.

TITLE II—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Miscellaneous Provisions

SEC. 201. REVISION OF PAYMENTS FOR GRADUATE MEDICAL EDUCATION TO PROMOTE PRIMARY CARE SERVICES.

(a) **DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.**—

(1) **TREATMENT OF PRIMARY CARE AND NON-PRIMARY CARE RESIDENTS IN INITIAL RESIDENCY PERIOD.**—Section 1886(h)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(C)(ii)) is amended by striking “is 1.00,” and inserting the following: “is—

- “(I) 1.1, in the case of a resident who is a primary care resident;
- “(II) 1.0, in the case of a resident who is not a primary care resident and who specializes in internal medicine, pediatrics, or obstetrics and gynecology; or
- “(III) .85, in the case of a resident not described in subclauses (I) or (II).”.

(2) **WEIGHTING FACTOR AFTER INITIAL RESIDENCY PERIOD.**—Section 1886(h)(4)(C)(iv) of such Act (42 U.S.C. 1395ww(h)(4)(C)(iv)) is amended by striking “.50” and inserting “.75”.

(3) **DEFINITION.**—Section 1886(h)(5) of such Act (42 U.S.C. 1395ww(h)(5)) is amended—

- (A) by redesignating subparagraph (H) as subparagraph (I); and
- (B) by inserting after subparagraph (G) the following new subparagraph:

“(H) **PRIMARY CARE RESIDENT.**—The term ‘primary care resident’ means (in accordance with criteria established by the Secretary) a resident being trained in a distinct program of family practice medicine, general internal medicine, general pediatrics, or emergency medicine.”.

(b) **STUDY AND REPORT ON MEDICARE GME PAYMENTS.**—

(1) **STUDY.**—The Secretary of Health and Human Services shall conduct a study of the methodology used to determine payments to hospitals under the medicare program for the costs of medical residency training programs, and shall include in the study an assessment of the impact of the amendments to such methodology made under subsection (a) on such payments and on the number of physicians who will receive residency training in primary care programs.

(2) **REPORT.**—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report any recommendations considered appropriate by the Secretary for additional modifications to the methodology used to determine payments to hospitals under the medicare program for the costs of medical residency training programs that will increase the number of physicians receiving residency training in primary care programs and will promote the provision of primary care services.

(c) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after the first October 1 that occurs after the expiration of the 1-year period that begins on the date the Secretary submits a report to Congress under subsection (b)(2).

SEC. 202. NO MEDICARE SECONDARY PAYOR DENIAL BASED ON FAILURE TO COMPLETE QUESTIONNAIRE.

Section 1862(b)(2) of the Social Security Act (42 U.S.C. 1395y(b)(2)) is amended by adding at the end the following new subparagraph:

“(C) TREATMENT OF QUESTIONNAIRES.—The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.”.

SEC. 203. ADJUSTMENT IN MEDICARE CAPITATION PAYMENTS TO ACCOUNT FOR REGIONAL VARIATIONS IN APPLICATION OF SECONDARY PAYOR PROVISIONS.

(a) IN GENERAL.—Section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) is amended by adding at the end the following new sentence: “In establishing the adjusted average per capita cost for a geographic area, the Secretary shall take into account the differences between the proportion of individuals in the area with respect to whom there is a group health plan that is a primary payor (within the meaning of section 1862(b)(2)(A)) compared to the proportion of all such individuals with respect to whom there is such a group health plan.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contracts entered into for years beginning with 1994.

SEC. 204. REPEAL OF PRO PRECERTIFICATION REQUIREMENT FOR CERTAIN SURGICAL PROCEDURES.

(a) IN GENERAL.—Section 1164 of the Social Security Act (42 U.S.C. 1320c-13) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 1154 of such Act (42 U.S.C. 1320c-3) is amended—

(A) in subsection (a), by striking paragraph (12), and

(B) in subsection (d), by striking “(and except as provided in section 1164)”.

(2) Section 1833 of such Act (42 U.S.C. 1395l) is amended—

(A) in subsection (a)(1)(D)(i), by striking “, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)”;

(B) in subsection (a)(1), by striking clause (G);

(C) in subsection (a)(2)(A), by striking “to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),”;

(D) in subsection (a)(2)(D)(i)—

(i) by striking “basis,” and inserting “basis or”, and

(ii) by striking “, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)”;

(E) in subsection (a)(3), by striking “and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion”; and

(F) in the first sentence of subsection (b), by striking “, (4) such deductible” and all that follows through “and (5)” and inserting “and (4)”.

(3) Section 1834(g)(1)(B) of such Act (42 U.S.C. 1395m(g)(1)(B)) is amended by striking “and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion”.

(4) Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) by adding “or” at the end of paragraph (14),

(B) by striking “; or” at the end of paragraph (15) and inserting a period, and

(C) by striking paragraph (16).

(5) The third sentence of section 1866(a)(2)(A) of such Act (42 U.S.C. 1395w(a)(2)(A)) is amended by striking “, with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after January 1, 1993.

SEC. 205. IMPROVED OUTREACH FOR QUALIFIED MEDICARE BENEFICIARIES.

The Secretary of Health and Human Services shall establish and implement a method for obtaining information from newly eligible medicare beneficiaries that may be used to determine whether such beneficiaries may be eligible for medical

assistance for medicare cost-sharing under State medicaid plans as qualified medicare beneficiaries, and for transmitting such information to the State in which such a beneficiary resides.

SEC. 206. DEMONSTRATION PROJECT REGARDING FURNISHING OF DURABLE MEDICAL EQUIPMENT BY PHYSICIAN-OWNED ONCOLOGY FACILITY.

(a) **IN GENERAL.**—The Secretary of Health and Human Services shall conduct a 2-year demonstration project (at an appropriate site) under which the provisions of section 1877 of the Social Security Act shall not apply with respect to the provision of durable medical equipment provided on referral from a medical oncologist, if such referral meets the conditions described in subsection (b).

(b) **CONDITIONS FOR REFERRAL.**—A referral meets the conditions of this subsection if the referral consists of a prescription or order issued by the medical oncologist for an external ambulatory infusion pump, together with the drugs, biologicals, and nutrient solution which must be put directly into the pump to achieve the pump's therapeutic benefits or to assure the pump's proper function, as part of a treatment for cancer (or complications thereof).

(c) **SITE FOR PROJECT.**—The site selected for the demonstration project under subsection (a) shall be located in a State with laws in effect that prohibit physician dispensing of prescription drugs, shall have experience in the provision of the services that are the subject of the referral described in subsection (b), and shall be of sufficient size to allow for the proper evaluation of the project.

(d) **REPORT.**—Upon the conclusion of the demonstration project conducted under subsection (a), the Secretary shall submit a report on the project to Congress, and shall include in the report an evaluation of the costs and benefits of the services covered under the project, together with any recommendation the Secretary considers appropriate.

Subtitle B—Provisions Relating to Medicare Supplemental Insurance Policies

SEC. 211. STANDARDS FOR MEDICARE SUPPLEMENTAL INSURANCE POLICIES.

(a) **SIMPLIFICATION OF MEDICARE SUPPLEMENTAL POLICIES.**—

(1) Section 4351 of the Omnibus Budget Reconciliation Act of 1990 (in this subtitle referred to as “OBRA-1990”) is amended by striking “(a) **IN GENERAL.**—”.

(2) Section 1882(p) of the Social Security Act is amended—

(A) in paragraph (1)(A)—

(i) by striking “promulgates” and inserting “changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate”,

(ii) by striking “(such limitations, language, definitions, format, and standards referred to collectively in this subsection as ‘NAIC standards’), and

(iii) by striking “included a reference to the NAIC standards” and inserting “were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the ‘1991 NAIC Model Regulation’)”;

(B) in paragraph (1)(B)—

(i) by striking “promulgate NAIC standards” and inserting “make the changes in the revised NAIC Model Regulation”,

(ii) by striking “limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as ‘Federal standards’)” and inserting “a regulation”, and

(iii) by striking “included a reference to the Federal standards” and inserting “were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the ‘1991 Federal Regulation’)”;

(C) in paragraph (1)(C)(i), by striking “NAIC standards or the Federal standards” and inserting “1991 NAIC Model Regulation or 1991 Federal Regulation”;

(D) in paragraphs (1)(C)(ii)(I), (1)(E), (2), and (9)(B), by striking “NAIC or Federal standards” and inserting “1991 NAIC Model Regulation or 1991 Federal Regulation”;

(E) in paragraph (2)(C), by striking “(5)(B)” and inserting “(4)(B)”;

(F) in paragraph (4)(A)(i), by inserting “or paragraph (6)” after “(B)”;

(G) in paragraph (4), by striking "applicable standards" each place it appears and inserting "applicable 1991 NAIC Model Regulation or 1991 Federal Regulation";

(H) in paragraph (6), by striking "in regard to the limitation of benefits described in paragraph (4)" and inserting "described in clauses (i) through (iii) of paragraph (1)(A)";

(I) in paragraph (7), by striking "policyholder" and inserting "policyholders";

(J) in paragraph (8), by striking "after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection" and inserting "on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A)";

(K) in paragraph (9), by adding at the end the following new subparagraph:

"(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C)."; and

(L) in paragraph (10), by striking "this subsection" and inserting "paragraph (1)(A)(i)".

(3) The Secretary of Health and Human Services shall publish in the Federal Register a list described in section 1882(p)(10) of the Social Security Act by not later than December 31, 1992.

(4)(A) For purposes of section 1882 of the Social Security Act, when the National Association of Insurance Commissioners modifies its 1991 NAIC Model Regulation (adopted in July 1991) to delete from section 15C the exception which begins with "unless", such modification shall be considered to be part of that Regulation under such section. If subsection (p)(1)(A) of such section is applicable, until the Association makes such modification, such section shall be applied as if such exception had been deleted.

(B)(i) If the Secretary of Health and Human Services identifies a State as requiring legislative action in order to conform its regulatory program to the modification described in this paragraph, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such modification until the close of the first regular legislative session that begins after the date of the enactment of this Act.

(ii) If the Secretary identifies a State as requiring changes in its regulations, but not requiring legislative action, in order to conform its regulatory program to the modification described in this paragraph, the State regulatory program shall not be considered to be out of compliance with the requirements of such section due solely to failure to make such modification until the State has been permitted the minimal period of time determined by the Secretary to be required to make such required changes; but in no case shall such period of time extend beyond the close of the first regular legislative session of the State that begins after the date of the enactment of this Act.

(b) **GUARANTEED RENEWABILITY.**—Section 1882(q) of the Social Security Act is amended—

(1) in paragraph (2), by striking "paragraph (2)" and inserting "paragraph (4)", and

(2) in paragraph (4), by striking "the succeeding issuer" and inserting "issuer of the replacement policy".

(c) **ENFORCEMENT OF STANDARDS.**—

(1) Section 1882(a)(2) of the Social Security Act is amended—

(A) in subparagraph (A), by striking "NAIC standards or the Federal standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation", and

(B) by striking "after the effective date of the NAIC or Federal standards with respect to the policy" and inserting "on and after the effective date specified in subsection (p)(1)(C)".

(2) The sentence in section 1882(b)(1) of the Social Security Act added by section 4353(c)(5) of OBRA-1990 is amended—

(A) by striking "The report" and inserting "Each report",

(B) by inserting "and requirements" after "standards",

(C) by striking "and" after "compliance", and

(D) by striking the comma after "Commissioners".

(3) Section 1882(g)(2)(B) of the Social Security Act is amended by striking "Panel" and inserting "Secretary".

(4) Section 1882(b)(1) of such Act is amended by striking "the the Secretary" and inserting "the Secretary".

(d) PREVENTING DUPLICATION.—

(1) Section 1882(d)(3)(A) of the Social Security Act is amended—

(A) by amending the first sentence to read as follows:

"(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title—

"(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

"(II) a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

"(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.";

(B) by designating the second sentence as clause (ii) and, in such clause, by striking "the previous sentence" and inserting "clause (i)";

(C) by designating the third sentence as clause (iii) and, in such clause—

(i) by striking "the previous sentence" and inserting "clause (i) with respect to the sale of a medicare supplemental policy", and

(ii) by striking "the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled" and inserting "the individual is not entitled to benefits under another medicare supplemental policy"; and

(D) by striking the last sentence.

(2) Section 1882(d)(3)(B) of the Social Security Act is amended—

(A) in clause (ii)(II), by striking "65 years of age or older",

(B) in clause (iii)(I), by striking "another medicare" and inserting "a medicare",

(C) in clause (iii)(I), by striking "such a policy" and inserting "a medicare supplemental policy",

(D) in clause (iii)(II), by striking "another policy" and inserting "a medicare supplemental policy", and

(E) by amending subclause (III) of clause (iii) to read as follows:

"(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under title XIX, the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if a State medicaid plan under such title pays the premiums for the policy, or, in the case of a qualified medicare beneficiary described in section 1905(p)(1), if the State pays less than the individual's full liability for medicare cost-sharing (as defined in section 1905(p)(3))."

(3)(A) Section 1882(d)(3)(C) of the Social Security Act is amended—

(i) by striking "the selling" and inserting "(i) the sale or issuance", and

(ii) by inserting before the period at the end the following: ", (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under title XIX) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 90 days after the date the statements are developed under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this title, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual".

(B) Section 1882(d)(3) of such Act is amended by adding at the end the following:

"(D)(i) If, within the 90-day period beginning on the date of the enactment of this subparagraph, the National Association of Insurance Commissioners develops (after consultation with consumer and insurance industry representatives) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, as separate types of policies, policies paying directly to the

beneficiary fixed, cash benefits) which are sold to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved.

"(ii) If the Association does not develop the statement described in clause (i) within the 90-day period specified in such clause, the Secretary shall promulgate (after consultation with consumer and insurance industry representatives and not later than 90 days after the end of such period) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits) which are sold to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved."

(C) The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act shall not apply to an application made for a policy or plan before 90 days after the date of the enactment of this Act.

(4) Subparagraphs (A) and (B) of section 1882(q)(5) of the Social Security Act are amended by striking "of the Social Security Act".

(e) LOSS RATIOS AND REFUNDS OF PREMIUMS.—

(1) Section 1882(r) of the Social Security Act is amended—

(A) in paragraph (1), by striking "or sold" and inserting "or renewed";

(B) in paragraph (1)(A), by inserting "for periods after the effective date of these provisions" after "the policy can be expected";

(C) in paragraph (1)(A), by striking "Commissioners," and inserting "Commissioners");

(D) in paragraph (1)(B), by inserting before the period at the end the following: ", treating policies of the same type as a single policy for each standard package";

(E) by adding at the end of paragraph (1) the following: "For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under the policies after such date.";

(F) in the first sentence of paragraph (2)(A), by striking "by policy number" and inserting "by standard package";

(G) by striking the second sentence of paragraph (2)(A) and inserting the following: "Paragraph (1)(B) shall not apply to a policy until 12 months following issue. In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until January 1, 1994.";

(H) in the last sentence of paragraph (2)(A), by striking "in order" and all that follows through "are effective";

(I) in paragraph (2), by striking "policy year" each place it appears and inserting "calendar year";

(J) in paragraph (4), by striking "disallowance", "loss-ratios", and "loss-ratio" and inserting "disallowance", "loss ratios", and "loss ratio", respectively;

(K) in paragraph (6)(A), by striking "issues a policy in violation of the loss ratio requirements of this subsection" and "such violation" and inserting "fails to provide refunds or credits as required in paragraph (1)(B)" and "policy issued for which such failure occurred", respectively; and

(L) in paragraph (6)(B), by striking "to policyholders" and inserting "to the policyholder or, in the case of a group policy, to the certificate holder".

(2) Section 1882(b)(1) of the Social Security Act is amended by transferring and inserting the subparagraph (G) added by section 4355(c)(3) of OBRA-1990 immediately after the subparagraph (F) added by section 4353(c)(3) of that Act.

(3) Section 4355(d) of OBRA-1990 is amended by striking "sold or issued" and all that follows and inserting "issued or renewed on or after the date specified in section 1882(p)(1)(C) of the Social Security Act."

(4)(A) For purposes of section 1882 of the Social Security Act, when the National Association of Insurance Commissioners modifies its 1991 NAIC Model Regulation (adopted in July 1991) to apply (in the manner provided in this subsection) the loss ratio and premium refund provisions of such Regulation to

medicare supplemental policies issued prior to, but renewed after, the date specified in subsection (p)(1)(C) of such section, such modification shall be considered to be part of that Regulation under such section. If subsection (p)(1)(A) of such section is applicable, until the Association makes such modification, such section shall be applied as if the loss ratio and premium refund provisions in the 1991 Model Regulation were applicable (in the manner provided in this subsection) to medicare supplemental policies renewed after the date specified in subsection (p)(1)(C) of such section. Notwithstanding the previous provisions of this subparagraph, in the case of a medicare supplemental policy issued prior to such date, such modified Regulation shall not apply to the loss ratio or premiums for periods before January 1, 1993.

(B)(i) If the Secretary of Health and Human Services identifies a State as requiring legislative action in order to conform its regulatory program to the modification described in subparagraph (A), the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such modification until the close of the first regular legislative session that begins after the date of the enactment of this Act.

(ii) If the Secretary identifies a State as requiring changes in its regulations, but not requiring legislative action, in order to conform its regulatory program to the modification described in subparagraph (A), the State regulatory program shall not be considered to be out of compliance with the requirements of such section due solely to failure to make such modification until the State has been permitted the minimal period of time determined by the Secretary to be required to make such required changes; but in no case shall such period of time extend beyond the close of the first regular legislative session of the State that begins after the date of the enactment of this Act.

(f) TREATMENT OF HMO'S.—

(1) Section 1882(g)(1) of the Social Security Act is amended by striking “a health maintenance organization or other direct service organization” and all that follows through “1833” and inserting “an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 or, during the 1-year period beginning on the date specified in subsection (p)(1)(C), a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A)”.

(2) Section 4356(b) of OBRA-1990 is amended by striking “on the date of the enactment of this Act” and inserting “on the date specified in section 1882(p)(1)(C) of the Social Security Act”.

(g) PRE-EXISTING CONDITION LIMITATIONS.—Section 1882(s) of the Social Security Act is amended—

(1) in paragraph (2)(A), by striking “for which an application is submitted” and inserting “in the case of an individual for whom an application is submitted prior to or”,

(2) in paragraph (2)(A), by striking “in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B” and inserting “as of the first day of which the individual is 65 years of age or older and is enrolled for benefits under part B”, and

(3) in paragraph (2)(B), by striking “before it” and inserting “before the policy”.

(h) MEDICARE SELECT POLICIES.—

(1) Section 1882(t) of the Social Security Act is amended—

(A) in paragraph (1), by inserting “medicare supplemental” after “If a”,

(B) in paragraph (1), by striking “NAIC Model Standards” and inserting “1991 NAIC Model Regulation or 1991 Federal Regulation”,

(C) in paragraph (1)(A), by inserting “or agreements” after “contracts”,

(D) in subparagraphs (E)(i) and (F) of paragraph (1), by striking “NAIC standards” and inserting “standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation”, and

(E) in paragraph (2), by inserting “the issuer” before “is subject to a civil money penalty”.

(2) Section 1154(a)(4)(B) of the Social Security Act is amended—

(A) by inserting “that is” after “(or”, and

(B) by striking “1882(t)” and inserting “1882(t)(3)”.

(i) HEALTH INSURANCE COUNSELING.—Section 4360 of OBRA-1990 is amended—

- (1) in subsection (b)(2)(A)(ii), by striking "Act" and inserting "Act";
- (2) in subsection (b)(2)(D), by striking "services" and inserting "counseling";
- (3) in subsection (b)(2)(I), by striking "assistance" and inserting "referrals";
- (4) in subsection (c)(1), by striking "and that such activities will continue to be maintained at such level";
- (5) in subsection (d)(3), by striking "to the rural areas" and inserting "eligible individuals residing in rural areas";
- (6) in subsection (e)—

- (A) by striking "subsection (c) or (d)" and inserting "this section",

- (B) by striking "and annually thereafter, issue an annual report" and inserting "and annually thereafter during the period of the grant, issue a report",

- (C) in paragraph (1), by striking "State-wide", and

- (D) in subsection (f), by striking paragraph (2) and by redesignating paragraphs (3) through (5) as paragraphs (2) through (4), respectively; and

- (7) by redesignating the second subsection (f) (relating to authorization of appropriations for grants) as subsection (g).

(j) TELEPHONE INFORMATION SYSTEM.—

(1) Section 1804 of the Social Security Act is amended—

- (A) by adding at the end of the heading the following: "; MEDICARE AND MEDIGAP INFORMATION",

- (B) by inserting "(a)" after "1804.", and

- (C) by adding at the end the following new subsection:

"(b) The Secretary shall provide information via a toll-free telephone number on the programs under this title."

(2) Section 1882(f) of the Social Security Act is amended by adding at the end the following new paragraph:

"(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under title XIX to such policies)."

(3) Section 1889 of the Social Security Act is repealed.

(k) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1990; except that—

- (1) the amendments made by subsection (d)(1) shall take effect on the date of the enactment of this Act, but no penalty shall be imposed under section 1882(d)(3)(A) of the Social Security Act (for an action occurring after the effective date of the amendments made by section 4354 of OBRA-1990 and before the date of the enactment of this Act) with respect to the sale or issuance of a policy which is not unlawful under section 1882(d)(3)(A)(i)(II) of the Social Security Act (as amended by this section);

- (2) the amendments made by subsection (d)(2) shall apply to statements made on or after January 1, 1993; and

- (3) the amendment made by subsection (g)(2) shall take effect on January 1, 1993, and shall apply to individuals who attain 65 years of age or older on or after the effective date of section 1882(s)(2) of the Social Security Act (and, in the case of individuals who attained 65 years of age after such effective date and before January 1, 1993, and who were not covered under such section before January 1, 1993, the 6-month period specified in that section shall begin January 1, 1993).

PURPOSE AND SUMMARY

The purpose of the Miscellaneous Medicare Amendments Act of 1992 is to make a number of changes to Part B of the Medicare program, to revise certain provisions related to Parts A and B of the program, and to amend the federal requirements applicable to health insurance sold to the elderly.

The Committee bill consists of two titles. Title I includes provisions related to the Medicare Fee Schedule for physicians' services and matters related to the payment for other items and services covered under Part B of the program. Title II contains provisions related to Parts A and B of Medicare including amendments to the federal requirements imposed on private Medigap policies.

Specific provisions contained in Title I of the bill include restoration of separate payments for the interpretation of electrocardiograms; repeal of discounted payments to new physicians; required use of actual time in the determination of anesthesia payments; enforcement and clarification of extra-billing limits; use of the most recent data in determining the geographic adjustments under the fee schedule; and certain administrative and claims processing reforms. In addition, Title I provides for changes in the coverage of and payment for durable medical equipment (DME), extension of current limits on intraocular lenses, revision of the definition of Federally Qualified Health Centers, and a one-year extension of the Medicare flu vaccination demonstration.

Title II of the bill revises Medicare payments for graduate medical education following a study by the Secretary of HHS, prohibits payment denials based on a beneficiary's failure to complete a secondary payer questionnaire, adjusts Medicare payments to HMOs, repeals mandatory prior approval by PROs for selected procedures, improves outreach activities for qualified Medicare beneficiaries, and authorizes a demonstration regarding physician ownership of DME suppliers. This Title also clarifies and amends provisions related to the restrictions on the sale of duplicate health insurance policies, including Medigap policies.

BACKGROUND AND NEED FOR THE LEGISLATION

In the Omnibus Budget Reconciliation Acts of 1989 and 1990, Congress made sweeping changes to the Medicare program. Of particular significance were changes in the policies for compensating physicians and other practitioners for their services to Medicare beneficiaries. These physician payment reforms directed the Secretary to establish a fee schedule for physicians' services based on the resource costs of providing such services. This new Medicare Fee Schedule is being phased-in over a 4-year period that began January 1, 1992.

In addition, these reconciliation acts revised coverage and payment policy for durable medical equipment items and services. They also established new federal standards for the sale of private health insurance products, including Medigap policies.

COMMITTEE VIEWS

PROVISIONS RELATED TO PART B OF MEDICARE

It is now apparent, in the Committee's view, that a number of policy issue related to the implementation of provisions adopted in the prior budget reconciliation acts require further revision. In the case of the Medicare Fee Schedule, experience to date has indicated that certain payment policies are not consistent with congressional intent, and further, that certain provisions do not result in payments to physicians that are reasonable and equitable.

Thus, the Committee bill proposes a number of mid-course corrections to the fee schedule related to professional compensation for the interpretation of electrocardiograms (EKGs), for anesthesia services, and for physicians beginning practice. In each of these in-

stances, the Committee has determined that current payment policies do not result in fair compensation to practitioners.

In the case of payments for the interpretation of EKGs, current policy assumes that increases to visit and consultation services are sufficient to cover the costs of this professional service. Historically, Medicare has provided a separate payment for this service when it is found to be reasonable and necessary. However, the Committee recognizes that bundling payments for EKG interpretations in visit and consultation fees—as required by the provisions of OBRA 90—both over pays those practitioners who rarely, if ever, perform this service and under pays those who perform a significant number of such procedures. In the Committee's view, restoration of separate payments for the interpretation of EKGs would assure Medicare beneficiaries access to this important diagnostic service, and more fairly compensate physicians for their services.

In the case of payments to new physicians, the Committee is aware of the significant financial burdens many practitioners following the completion of post-graduate training programs. The cost of student loan payments and the expense of establishing a new practice can be significant. Current law provides for a reduction to the Medicare Fee Schedule during each of the first four years of practice. Payments are made at 80 percent of the amount otherwise recognized during the first year of practice, 85 percent in the second year, 90 percent in the third year, and 95 percent in the fourth year. These reductions are applied to the fee schedule amount or the recognized prevailing charge.

The Committee's bill repeals this policy and directs the Secretary to establish payments for new physicians and practitioners in the manner as prescribed for other physicians and practitioners who have been in practice for five or more years. This policy is more consistent with the intent of the Medicare Fee Schedule to establish payments on the basis of resource costs adjusted for geographic differences in the costs of practice and in the cost professional liability insurance.

Finally, in regard to anesthesia services, the Committee's bill directs the Secretary to continue current policy for the determination of professional fees for anesthesia services. Under the fee schedule, anesthesia fees are calculated as the product of work values, practice costs and actual time required to provide the service. The Secretary has indicated his intention to modify that procedure by substituting average time values for actual time.

The Committee believes that the use of average times would result in a failure to compensate fairly anesthesiologists and certified registered nurse anesthetists for their professional services. It is the Committee's view that many of the factors that determine the length of time required for the provision of anesthesia services are not within the control of the anesthesiologist or anesthetist. However, it is also evident that some of the variation in reported times for similar procedures is not fully accounted for by differences in patients or other known factors. While the Committee's bill requires continued recognition of actual times in determining payments for anesthesia services, the Committee urges the Secretary to monitor the variation in the times for similar services in order to identify more fully the causes of such variation.

Under current law, the actual charges of nonparticipating physicians to Medicare beneficiaries on an unassigned claim are subject to specified limits known as extra-billing limits. In 1992 these limits are equal to 120 percent of the recognized Medicare payment amount. This extra-billing limit will be 115 percent in 1993 and all subsequent years.

The language of the current law provision setting forth the requirements relating to extra-billing limits is not, in the Committee's view, sufficiently clear and complete to assure the intent of Congress is carried out fully. Specifically, current law fails to state directly that it is unlawful for a practitioner to bill a Medicare beneficiary in excess of the extra-billing limit on an unassigned claim. In addition, current law does not explicitly relieve the beneficiary of any liability for charges in excess of the extra-billing limit or require a refund of amounts paid by or on behalf of a beneficiary in excess of the limits. Finally, current law fails to apply the extra-billing limits uniformly to all physicians' services and permits certain services paid under the fee schedule to be billed on a non-assignment basis.

The Committee's bill includes provisions that clarify the intent of Congress in regard to the application of extra-billing limits and on mandatory assignment for the services of certain practitioners.

Several other administrative matters related to physicians' services are also included in the Committee's bill. Because the timeliness and representativeness of data used in the establishment of the geographic index to adjust the Medicare Fee Schedule is very critical, the Committee is directing the Secretary to use the most recent data available. The Secretary is also prohibited from charging fees to practitioners related to claims for their services, and is authorized to recognize certain substitute billing arrangements between physicians.

The Committee's bill makes several revisions to the coverage and payment of items of durable medical equipment (DME) that clarify provisions of current law related to certificates of medical necessity (CNM) and to the classification of nebulizers and aspirators. The Committee intends with respect to the classification of nebulizers and aspirators that the Secretary will exercise his discretion in order to assure that those items that may require servicing will be assigned to a category that provides coverage for servicing on an appropriate frequency.

PROVISIONS RELATED TO PARTS A AND B OF MEDICARE

Title II of the Committee's bill includes a number of provisions related to Parts A and B of the Medicare program. The Committee recognizes the significant contribution of the Medicare program to the financing of graduate medical education. The Congressional Budget Office estimates total Medicare outlays of \$4.4 billion for direct and indirect education payments in FY 1992. At the same time, the Committee also is concerned that the need for primary care services continues to exceed the supply of practitioners trained in the primary care specialties. In 1989, only 39 percent of residency positions were in primary care compared to 45 percent in

1980, while the total number of residents in training has increased 35 percent since 1980.

The Council on Graduate Medical Education in its most recent report finds increasing subspecialization in medicine is resulting in a corresponding shortage of physicians preparing for general practice. The Council further observes that growth in the number of subspecialists escalates health care costs, results in fragmentation of services, and increases the disparity between the numbers of rural and urban physicians.

These trends are particularly disturbing to the Committee in view of the growing reliance on organized systems of care where there is a greater need for generalists. For example, in one region of the Kaiser Permanente Health Plan, approximately 45 percent of physicians are in internal medicine, pediatrics and family practice. Nationally, only about 35 percent of physicians are in these specialties. In contrast, in most other industrialized countries, from 50 to 75 percent of physicians are generalists.

While the factors influencing the choice of medical specialty are many and interrelated, the Committee believes that adjustments in the methodology for determining direct graduate medical education payments would be helpful in achieving an increase in the supply of primary care practitioners. Current law provides direct medical education payments to hospitals based on Medicare's share of the hospital's direct costs for the program on a per resident basis. In allocating these direct costs, the count of full time residents who are in training beyond the initial period required for board certification is reduced by one-half.

The Committee's bill includes a revision to the methodology for counting residents in training that increases Medicare payments for residents in primary care specialties, maintains current policy for certain other specialty programs, and reduces payments for specialty programs where there is a surplus of such physicians in practice. As a result of concerns expressed by some Members of the Committee, the effective date for these changes in the methodology for counting full-time equivalent residents is delayed pending the results and the evaluation of a study to be carried out by the Secretary.

The Committee anticipates that the Secretary will complete the study of the impact of these changes on Medicare payments for graduate medical education and on the supply of primary care practitioners within two years. Congress would have a one-year period for review of the report and its recommendations, and the opportunity to further revise the policy described above. The effective date for these provisions, in the absence of further congressional action, would be October 1, 1996.

The Committee's bill also includes several provisions clarifying the application of the Medicare secondary payer policy, repealing the requirement for prior approval for certain surgical procedures by Peer Review Organizations (PROs), and strengthening the outreach activities related to the identification of beneficiaries eligible for assistance under the Qualified Medicare Beneficiary (QMB) program.

Finally, the Committee's bill incorporates a number of revisions and corrections to the OBRA 90 provisions related to Medicare

Supplemental Health Insurance (Medigap) policies. These amendments include the provisions of H.R. 1555, the Technical Correction Act of 1991, which passed the House on November 26, 1991.

In addition, the Committee's bill revises the Medigap standards to clarify the effective dates for compliance with the National Association of Insurance Commissioners (NAIC) 1991 Model Regulation, including the application of loss ratio standards and premium refund requirements for policies issued prior to the effective date established in OBRA 90 and renewed after such date.

The bill also clarifies the requirements for issuers or sellers of policies with respect to duplication. The NAIC is directed to develop a model disclosure notice for the different types of policies that will be subject to the non-duplication requirements. In addition, such policies are required to pay all benefits fully to the individual without regard to any other coverage. The provision of H.R. 1555 that would sunset these requirements January 1, 1994 is deleted. Finally, the bill more clearly restates Congressional intent that the open enrollment period for Medicare beneficiaries to purchase Medigap policies at age 65 includes those beneficiaries previously entitled to benefits because of their disability status.

During consideration of this legislation by the Committee, there was discussion of the need for a systematic examination of the effect of anti-trust policy on the access of Medicare beneficiaries to covered services and on the costs of such services. The Committee believes that such an undertaking could produce recommendations to improve the application and coordination of anti-trust policy, promote access, increase cooperation among providers, and constrain the costs of health services furnished to Medicare beneficiaries and to other Americans.

Therefore, the Committee recommends that the Secretary of Health and Human Services, in consultation with the Attorney General, the Director of the Office of Management and Budget, and the Chairman of the Federal Trade Commission, undertake a study of these issues and develop recommendations for consideration by the appropriate Committee of the Congress.

HEARINGS

The Committee's Subcommittee on Health and the Environment held two oversight hearings on the Medicare program that identified a number of the issues addressed in the Committee's bill. On July 11, 1991, the Subcommittee held an oversight hearing on implementation of the Medicare Fee Schedule for physicians' services. Witnesses at this hearing included the Administrator of the Health Care Financing Administration, the Prospective Payment Review Commission, the American Medical Association, the American Society of Internal Medicine, the American College of Physicians, the American Academy of Family Physicians, the American College of Surgeons, the American College of Radiology, the American Society of Anesthesiologists, and the American Psychiatric Association.

On November 15, 1991, the Subcommittee on Health and the Environment held a second oversight hearing on the Medicare HMO Risk-Contractor Program. Testimony was received from Rep. Lawrence J. Smith (D-FL), the General Accounting Office, the Health

Care Financing Administration, the Medicare Advocacy Project of Los Angeles, the HMO Patient Advocacy Committee, the American Association of Retired Persons, the Group Health Association of America, and the American Managed Care and Review Association.

COMMITTEE CONSIDERATION

On July 30, 1992, the Subcommittee on Health and the Environment met in open session to consider the Revised Subcommittee Print, dated July 29, 1992. The bill was ordered reported as a clean bill, by voice vote, a quorum being present. On July 31, 1992, Mr. Waxman, for himself and Messrs. Wyden, Towns, and Ritter, introduced the clean bill, H.R. 5748. On August 5, 1992, the Committee on Energy and Commerce met in open session and ordered reported the bill H.R. 5748 with amendments by voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee agrees with the findings of the Congressional Budget Office with respect to bill's effect on outlays and with respect to the pay-as-you-go effects of the bill for purposes of the Budget Enforcement Act. In the aggregate, for Fiscal Years 1993 through 1997, the Committee bill would reduce Medicare outlays, according to the Congressional Budget Office, by \$195 million.

BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 15, 1992.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared a revised letter of transmittal for the enclosed cost estimate for H.R. 5748, the Miscellaneous Medicare Amendments Act of 1992, as ordered reported by the House Committee on Energy and Commerce on August 5, 1992. The original letter contained a typographical error.

Enactment of this legislation would have direct spending implications and would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. As a result, the estimate required under clause 8 of House Rule XXI is attached.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER, *Director*.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill Number: H.R. 5748.
2. Bill Title: Miscellaneous Medicare Amendments Act of 1992.
3. Bill Status: As ordered reported by the House Committee on Energy and Commerce on August 5, 1992.
4. Bill Purpose: H.R. 5748 would amend title XVIII of the Social Security Act to make miscellaneous amendments to the Medicare program and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Direct spending:					
Budget Authority.....	0	-45	-45	-55	-50
Outlays.....	0	-45	-45	-55	-50
Amounts subject to appropriations action:					
Estimated Authorization Level.....	(1)	(1)	(1)	0	0
Estimated Outlays.....	(1)	(1)	(1)	0	0

¹ Less than \$500,000

The costs of this bill fall within budget function 570.

Basis of estimate

Provisions in the bill that CBO estimates to have significant costs or savings are discussed below. All provisions would become effective January 1, 1993.

Section 101—Permitting Separate Payment for Interpretation of Electrocardiograms: The bill would allow physicians to be reimbursed separately for interpreting electrocardiograms (EKGs) when they are performed in conjunction with physician visits or consultations. Currently the Health Care Financing Administration (HCFA) considers the payment to the physician for the interpretation of an EKG to be included in the payment for a visit or consultation. Physician reimbursement is determined by the Medicare Fee Schedule (MFS). The bill would reduce payments for all services other than EKG interpretations paid under the MFS to such an extent that the total payments under the MFS would be the same as in the absence of this section. While there would be no change in total payments under the MFS, there are direct spending effects from this section because other Medicare reimbursement rates are linked to MFS rates. In particular, rates paid to hospital outpatient departments (OPDs) for radiological services are tied to MFS payments for radiological services. Because the MFS radiolo-

gy rates would be reduced to offset separate reimbursements for EKGs, radiology rates paid to OPDs would also decline. The rates would decrease by approximately 1 percent, and therefore, CBO estimates that spending would decrease by \$5 million in fiscal year 1993 and by \$55 million over the five-year period.

Section 102—Payments for New Physicians: The bill would repeal the current payment rate limits for new physicians and health care practitioners. Under current law, payment rates for physicians and health care practitioners in their first year of treating Medicare patients are limited to 80 percent of the rates for physicians and practitioners with more than four years of Medicare experience. During the second through fourth years of experience, the limiting percentage is increased by 5 percentage points each year. This bill would reduce the payment rates for all physicians and practitioners under the MFS so that the increase in payments to new physicians would not increase overall payments under the MFS. As is the case under the EKG provision, the reduction in MFS payment rates will have the effect of lowering payments for OPD radiology services by about 1 percent. Thus, CBO estimates that spending under this section would fall by \$5 million in fiscal year 1993 and by \$55 million from 1993 through 1997.

Section 104—Enforcement and Application of Extra-billing Limits: This section would lower reimbursement rates for certain Medicare suppliers if they do not sign participation agreements stipulating that they accept assignment on all Medicare claims. Those accepting assignment agree to Medicare's reimbursement rates as payment in full and bill Medicare beneficiaries only for deductibles and copayments. Those not accepting assignment may bill Medicare beneficiaries for charges above Medicare approved rates. Non-participating physicians and suppliers may choose to accept assignment on a claim-by-claim basis. Reductions in payment rates of 5 percent currently are in effect for non-participating physicians. This section would extend these 5 percent reductions to certain types of suppliers who are not currently faced with reductions for non-participation. Medicare reimburses about \$350 million in charges to these suppliers. We assume that about one-third of these suppliers would become participating providers in 1993. We also assume that the participation rate would grow by about 10 percentage points per year. Savings from these penalties would be \$7 million in fiscal year 1993 and \$45 million over the five-year period.

Sections 108, 109, and 110—Study of Services of Medical Physicians, Study of Adjustments to Fee Schedules to Take into Account Practice-Related Taxes, and PHYSPRC Study of Radiology Services: The bill would mandate reports from three studies; two by the Secretary of the Department of Health and Human Services, and one by the Physician Payment Review Commission (PHYSPRC). CBO estimates that the cost of the studies would average approximately \$200,000 each, over a period of two years. These studies would be funded with appropriated funds and therefore there would be no impact on direct spending.

Section 112—Treatment of Nebulizers and Aspirators as Miscellaneous Items of Durable Medical Equipment: The bill would alter the reimbursement classification of nebulizers and aspirators. Under current law this equipment is listed as requiring "frequent

and substantial servicing,” and as such indefinite rental payments are made for these items. Oftentimes the result is that the rental payments exceed the purchase price of the item by a considerable amount. Further, Medicare will not pay to purchase these items. As frequent and substantial servicing is not currently necessary for these kinds of equipment, the provision would move them into a reimbursement category that permits purchase. Discussions with HCFA have indicated that one item would be listed under the “inexpensive and routinely purchased” category, and the others would be listed as “capped rental” items. The effect of this reclassification would be to limit reimbursement to purchase price, 105% of purchase price, or 120% of purchase price depending on the item and beneficiary choices. Because under current law rental payments greatly exceed purchase price for many beneficiaries, CBO estimates that this provision would result in savings. Based on HCFA data and current retail prices, CBO estimates this provision would save \$10 million in fiscal year 1993 and \$90 million over the five-year period.

Section 114—Treatment of Certain Indian Health Programs and Facilities as Federally-Qualified Health Centers: The bill would add outpatient health programs or facilities operated by a tribe or tribal organization to the Medicare definition of a Federally Qualified Health Center outpatient facility (FQHC). FQHCs are eligible for Medicare reimbursement for additional services, including routine physical examinations. In fiscal year 1991, outpatient health programs and facilities operated by tribes or tribal organizations received \$13 million in Medicare reimbursements. According to the Indian Health Service (IHS), there are 60,000 Indians with Medicare part B coverage. CBO assumed that 70 percent of eligible Indians would use services of these outpatient programs or facilities, and would visit these facilities an average of 5 times per year. Eligible programs would receive an average of \$30 per visit in Medicare reimbursements for additional services. Because the bill specifies an implementation date of January 1, 1993, CBO estimated a part-year effect in 1993. CBO estimates that the additional cost of Medicare reimbursement to these facilities would be \$3 million in fiscal year 1993, \$6 million in fiscal year 1994, \$7 million in each of fiscal years 1995 and 1996, and \$8 million in fiscal year 1997.

Section 115—Extension of Medicare Influenza Vaccination Demonstration Project Until April 1993. This section of the bill would extend funding for the Medicare influenza vaccination demonstration project, currently due to expire in September 1992, until April 1993. Current law limits expenditures under the demonstration to \$25 million per year. CBO estimates that there would be a small offset to the cost of the demonstration from reduced health care costs of beneficiaries who are vaccinated.

6. Pay-as-you-go considerations: Section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1995. The pay-as-you-go effects of the bill are as follows.

[By fiscal years, in millions of dollars]

	1993	1994	1995
Outlays.....	0	-45	-45
Receipts.....	(¹)	(¹)	(¹)

¹ Not applicable.

7. Estimated cost to State and local governments: None.

8. Estimate comparison: None

9. Previous CBO estimate: None.

10. Estimate prepared by: Scott Harrison, Connie Takata, Lisa Layman, and Alan Fairbank.

11. Estimate approved by: C.G. Nuckols, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE ESTIMATE ¹

The applicable cost estimate of this Act for all purposes of sections 252 and 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 shall be as follows:

[By fiscal years, in millions of dollars]

	1993	1994	1995
Outlays.....	0	-45	-45
Receipts.....	(¹)	(¹)	(¹)

¹ Not applicable.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4) of the rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill: the bill is not expected to have an inflationary impact on prices and costs in the operation of the national economy. The bill seeks to revise a number of Medicare policies to improve the accuracy and reasonableness of payments, and to strengthen the protections against extra-billing to Medicare beneficiaries. The Committee believes these changes would assure more prudent use of Medicare funds and lower the growth in overall Medicare expenditures.

SECTION-BY-SECTION ANALYSIS AND DISCUSSION

SECTION 1. SHORT TITLE; TABLE OF CONTENTS

Section 1 cites the Act as the "Miscellaneous Medicare Amendments Act of 1992" and includes a table of contents listing the provisions of the Act.

¹ An estimate of H.R. 5748, the Miscellaneous Medicare Amendments Act of 1992, as ordered reported by the House Committee on Energy and Commerce on August 5, 1992. This estimate was transmitted by the Congressional Budget Office on September 14, 1992.

Title I—Provisions Relating to Part B

Subtitle A—Payment for Physicians' Services

SECTION 101. PERMITTING SEPARATE PAYMENT FOR INTERPRETATION OF ELECTROCARDIOGRAMS

This section of the Committee bill repeals the current prohibition against separate payments to physicians for the interpretation of electrocardiograms (EKGs). Separate payments for the interpretation of EKGs are effective for services furnished on or after January 1, 1993. Relative value units for visit and consultation services related to the provision of EKGs are removed, and further adjustments are made to the relative values for all services and to the average historical payment amounts to assure budget neutrality for the fee schedule and during the transition period to the full fee schedule.

SECTION 102. PAYMENT FOR NEW PHYSICIANS

This section of the Committee bills repeals the requirement to reduce Medicare payments to physicians and other health care practitioners during the first four years of furnishing covered services to Medicare beneficiaries. Adjustments to the relative values of all other physician services and to the average historical payment amount are required to assure budget neutrality. In addition, this section requires separate adjustments for payments made to non-physician health care practitioners to assure budget neutrality as a result of the repeal of current policy for such new practitioners. These provisions are effective for services furnished on or after January 1, 1993.

SECTION 103. ANESTHESIA TIME

This section of the Committee bill directs the Secretary of Health and Human Services to maintain the current payment methodology for determining payments for anesthesia services. Under regulations promulgated by the Secretary, the actual time required for an anesthesia procedure is included in the calculation of the fee for professional services. The Health Care Financing Administration has stated its intention to substitute average time for actual time. The Committee believes that such a change would result in both over and under payments for these services, and would not take sufficient account of the factors that determine the length of time for a particular anesthesia procedure.

SECTION 104. ENFORCEMENT AND APPLICATION OF EXTRA-BILLING LIMITS

Subsection (a) clarifies the current policy for applying limitations on charges to beneficiaries by nonparticipating physicians with respect to claims submitted on a non-assignment basis. Under current law, actual charges for services submitted on a non-assignment basis may not exceed 120 percent of the Medicare approved payment amount in 1992 or 115 percent of the approved payment amount in 1993.

This provision explicitly prohibits physician billing in excess of the limiting charge, eliminates any beneficiary liability for amounts in excess of the limiting charge, and requires physician refunds of credits, at the patient's option, to any outstanding balance of the patient within 30 days in the amount of the excess charges billed. Physicians who knowingly and willfully violate these billing limits on a repeated basis may be excluded from the Medicare program and assessed civil monetary penalties.

Subsection (b) clarifies the intent of current law to apply the limiting charge policy of Subsection (a) to services provided by nonparticipating suppliers or other persons submitting claims on a non-assignment basis. The effect of this provision is to ensure that payments to suppliers and other persons for the technical components of services paid under the Medicare Fee Schedule are subject to the 5 percent differential between participating and non-participating persons, and are subject to all other requirements for claims submitted on a non-assignment basis.

Subsection (c) further clarifies current law with respect to the requirement that any payment for a covered service furnished by a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse mid-wife, clinical social worker or clinical psychologist can only be made on an assignment-related basis. Any changes in excess of the allowable deductible or coinsurance amounts are prohibited. Beneficiaries are not liable for such prohibited charges, and practitioners who knowingly and willfully violate these requirements are subject to the same sanctions prescribed for physicians under Subsection (a).

The amendments made by this section are effective for services furnished on or after January 1, 1993.

SECTION 105. REQUIRING CONSULTATION WITH REPRESENTATIVES OF PHYSICIANS IN REVIEWING GEOGRAPHIC ADJUSTMENT FACTORS

This section directs the Secretary to consult with representatives of physicians in carrying out requirements to review the indices and the index values used to apply the geographic practice cost index (GPCI) to payments made under the Medicare Fee Schedule. Such reviews are required to be conducted not less often than every three years.

The Committee recognizes the importance of accurate and timely data in making adjustments to the fee schedule. Current geographic practice cost indices are based on the best available data which is in some cases over a decade old. The Committee observes that medical societies can be a resource in identifying available and comparable data for use in determining these important adjustments. The Committee expects whenever feasible that the Secretary will revise the GPCI to incorporate the most recent and appropriate data to assure that payments made under the fee schedule fairly reflect geographic differences in the costs associated with the provision of physician services.

The section is effective for physicians' services furnished on or after January 1, 1993.

SECTION 106. USE OF MOST RECENT DATA IN GEOGRAPHIC ADJUSTMENT

This section of the Committee bill directs the Secretary to use the most recent available data relating to physician practice expenses, malpractice premium expenses, and physician work in establishing the geographic practice cost index (GPCI) used to adjust payments under the Medicare Fee Schedule.

SECTION 107. ADMINISTRATION OF CLAIMS RELATING TO PHYSICIANS' SERVICES

Subsection (a) prohibits the Secretary from imposing any fees related to the filing of claims for physicians' services, for claims errors or denials, for administrative appeals, for obtaining unique identifying numbers, or for responding to inquiries concerning the status of pending claims. The Committee believes that the cost of these activities should be covered by the contracts with carriers, and therefore it would be inappropriate and duplicative to assess fees for these services to those persons submitting claims for payment under the Medicare program.

Subsection (b) clarifies the conditions under which the Secretary can recognize substitute billing arrangements between two physicians. Such substitute billing arrangements must either be informal, reciprocal coverage agreements or per diem or other fee-for-time agreements. The duration of such agreements is limited to 60 continuous days, and claims for services provided pursuant to such agreements must include the unique identifying number of both physicians. These requirements are effective for services provided under such arrangements in the first month beginning 60 days after the enactment of this Act.

The Committee recognizes that such arrangements are necessary and appropriate. However, effective administration of the program requires carriers to have the capability of identifying and monitoring such agreements to ensure appropriate application of Medicare coverage and payment policies.

SECTION 108. STUDY OF SERVICES OF MEDICAL PHYSICISTS

This section of the Committee bill directs the Secretary of Health and Human Services to conduct a study of the payments made for the services of medical physicians under Part B of Medicare. The study will seek to identify the circumstances under which these services are medically appropriate and by whom they may be appropriately provided. The Secretary is required to submit a report to Congress concerning the findings of this study and any recommendations regarding the method of payment under Part B for these services when they are furnished by medical physicists by July 1, 1993.

SECTION 109. STUDY OF ADJUSTMENTS TO FEE SCHEDULES TO TAKE INTO ACCOUNT PRACTICE-RELATED TAXES

This section directs the Secretary of Health and Human Services to conduct a study of the feasibility and desirability of adjusting the Medicare Fee Schedule to take account of State and local taxes applied to the provision of physicians' services. A report to Con-

gress on the findings of the study is required by July 1, 1993. The Committee is interested in learning more about the impact of such taxes on the cost of physician practice, and the extent to which such amounts are reflected in charges of physicians to Medicare and other public and private payers.

SECTION 110. PHYSPRC STUDY OF RADIOLOGY SERVICES

This section directs the Physician Payment Review Commission (PHYSPRC) to conduct a study comparing physician behavioral responses to payments determined under the Medicare Fee Schedule and payments determined under the fee schedule for radiology service established in 1989. The results of the study including any appropriate recommendations are to be included in the Commission's annual report to Congress.

The Committee's intent in requesting this study is to develop additional information concerning the amount of payments and the volume of radiology services provided under the separate radiology fee schedule which was applied until January 1, 1992, and the payments for and the volume of such services under the current Medicare Fee Schedule. At hearings conducted by the Subcommittee on Health and the Environment on July 11, 1991, the American College of Radiology testified that the methodology for incorporating the separate radiology fee schedule in the new fee schedule for all physicians' services resulted in greater than anticipated reductions in Medicare payments for radiology services.

The Committee anticipates that this report will identify the factors, including the method for recognizing practice costs and the assumptions concerning the behavioral response to fee changes, that resulted in the fee reductions. The Committee also expects that the study will compare the changes in the volume of radiology services provided before and after implementation of the radiology fee schedule in 1989, and before and after the payments for radiology services were included in the Medicare Fee Schedule. Of particular interest to the Committee will be information and analysis of the differences between different specialties in the provision of the same radiology services.

Subtitle B—Payment for Other Items and Services

SECTION 111. DISTRIBUTION OF CERTIFICATES OF MEDICAL NECESSITY BY SUPPLIERS OF DURABLE MEDICAL EQUIPMENT

This section revises current law with respect to the completion of certificates of medical necessity (CMNs) required for coverage of certain items of durable medical equipment. The prohibition against the distribution of completed or partially completed CMNs by suppliers of durable medical equipment is modified to permit suppliers to include the following information: the patient's name and address; description of the item; and any product code identifying the item.

The Committee notes that the Health Care Financing Administration has notified the Medicare carriers to permit such information to be completed by a supplier before submitting the CMN to the prescribing physician. The Committee believes this change

clarifies the intent of the original provision included in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). It is essential, in the Committee's view, for physicians to document in the CMN the medical necessity and reasonableness of their prescriptions for items of durable medical equipment, taking into account a patient's clinical condition and other appropriate factors.

SECTION 112. TREATMENT OF NEBULIZERS AND ASPIRATORS AS MISCELLANEOUS ITEMS OF DURABLE MEDICAL EQUIPMENT

This section of the Committee bill deletes the requirement of current law that nebulizers and aspirators be assigned to a designated category of durable medical equipment (DME). As a result of amendments enacted in 1987, nebulizers and aspirators were classified in the category of items requiring frequent and substantial servicing. Items assigned to this category are available to beneficiaries only on a rental basis.

The Committee believes that the Secretary should be given the discretion to assign these items to the appropriate DME category, taking into account the requirement, if any, for routine maintenance and servicing, and the most economical arrangement for making such items available to patients who need them.

This provision is effective for items furnished on or after January 1, 1993.

SECTION 113. 2-YEAR EXTENSION OF PAYMENT LIMIT ON INTRAOCULAR LENSES

This section of the Committee bill extends the current \$200 payment limit for intraocular lenses provided to Medicare beneficiaries through December 31, 1994. The Committee adopted this amendment to prevent the Secretary from promulgating a rule that would further reduce payments for intraocular lenses. The Committee also notes that H.R. 1555, which passed the House November 26, 1991, includes a provision directing the Secretary to establish a process for reviewing the appropriateness of the payment for new technology intraocular lenses approved by the Food and Drug Administration. If that amendment is enacted, the Secretary will have additional authority with respect to payment amounts for intraocular lenses under the Medicare program.

SECTION 114. TREATMENT OF CERTAIN INDIAN HEALTH PROGRAMS AND FACILITIES AS FEDERALLY QUALIFIED HEALTH CENTERS

This section of the Committee bill includes outpatient health programs and facilities operated by tribes or tribal organizations under the Indian Self-Determination Act in the definition of Federally Qualified Health Centers (FQHCs). Under current law these programs and facilities are included in the definition of FQHCs for purposes of the Medicaid program. This amendment makes the Medicare definition of FQHCs the same as that provided under Title XIX of the Social Security Act. Under current law (Section 1880 of the Social Security Act), hospitals and skilled nursing facilities operated by the Indian Health Service are eligible for Medicare payments.

This amendment reflects the Committee's intent with respect to the recognition of FQHCs under the Medicare program as provided for in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). This amendment is effective as if included in OBRA 1990.

SECTION 115. EXTENSION OF MEDICARE INFLUENZA VACCINATION
DEMONSTRATION PROJECT UNTIL APRIL 1993

This section of the Committee bill extends the influenza vaccination demonstration program under Medicare through March 31, 1993. The current demonstration authority expires September 30, 1992. Under the terms of the demonstration project established in OBRA 1987, the Secretary is required to report to Congress not later than April 1, 1993 on the results of the project, and, unless the Secretary finds that covering the flu vaccine is not cost-effective, the benefit will be included in the Medicare program one month after the report is received by Congress.

The purpose of this amendment is to continue coverage of the flu season. During the 1991-92 period, it is estimated that over 2.5 million doses of the vaccine were administered. The Committee feels that it is essential to extend the demonstration project sites during the period of the Secretary's evaluation of the first four years of the project and prior to the incorporation of the benefit under the Medicare program.

Title II—Provisions Relating to Parts A and B

Subtitle A—Miscellaneous Provisions

SECTION 201. REVISION OF PAYMENTS FOR GRADUATE MEDICARE
EDUCATION TO PROMOTE PRIMARY CARE SERVICES

This section of the Committee bill revises the weighting factors in current law used to determine Medicare direct education payments to hospitals with graduate medical education programs. This amendment increases the weighting factors applied to primary care residents during their initial residency period to 1.1. For residents in internal medicine, pediatrics, obstetrics or gynecology during the initial residency period the weighting factor is 1. All other residents during the initial residency period are weighted at .85. Following the initial residency period, all residents are weighted at .75.

This section also defines "primary care resident" as a resident participating in a distinct program of family practice medicine, general internal medicine, general pediatrics, or emergency medicine.

Prior to the effective date of these amendments, the Committee bill directs the Secretary to conduct a 2-year study of the methodology used to determine payments to hospitals for the costs of graduate medical education programs. The study is to include an assessment of the impact of the changes included in this section on payments to hospitals and on the number of primary care residents produced. The report will also include recommendations of the Secretary regarding further modifications to the method for determining hospital graduate medical education payments and for increas-

ing the number of primary care training programs and access to primary care services.

The Committee expects the Secretary to consider the appropriateness of revising the definition of primary care resident in order to increase the supply of physicians who are likely to expand access to primary care services. For example, the Committee notes that the July 1992 draft report of the Council on Graduate Medical Education recommends that preventive medicine residency programs should be treated in the same manner as other primary care programs.

The effective date for the changes in the weighting factors and in the definition of primary care residents included in this section is the first October 1 that occurs after the expiration of the 1-year period that begins on the date the Secretary submits the report to Congress required by this section. The Committee expects that the earliest effective date would be October 1, 1996.

SECTION 202. NO MEDICARE SECONDARY PAYOR DENIAL BASED ON FAILURE TO COMPLETE QUESTIONNAIRE

This section of the Committee bill prohibits the Secretary from denying payment for covered services solely on the grounds that a beneficiary has failed to complete a questionnaire concerning the existence of other health plan coverage that would be regarded as a primary plan under Medicare's secondary payor policy. The Committee recognizes the importance of collecting information about other health plans in order to fully and fairly enforce the requirements related to the secondary payor policy. However, it is not appropriate, in the Committee's view, for the Secretary to condition the payment of claims for covered services on the completion of a survey by beneficiaries.

SECTION 203. ADJUSTMENT IN MEDICARE CAPITATION PAYMENTS TO ACCOUNT FOR REGIONAL VARIATIONS IN APPLICATION OF SECONDARY PAYOR PROVISIONS

This section of the Committee will requires the Secretary, by January 1, 1994, to make adjustments in the calculation of the adjusted average per capita cost (AAPCC) payment to eligible health maintenance organizations and competitive medical plans at a county level that take into account the proportion of beneficiaries residing in the county who have employment-related group health insurance which under current law is required to be primary to the Medicare program. The purpose of this provision is to use a more accurate and equitable payment calculation in areas where the extent of primary health plan coverage among Medicare beneficiaries is above or below average.

SECTION 204. REPEAL OF PRO PRECERTIFICATION REQUIREMENT FOR CERTAIN SURGICAL PROCEDURES

The section repeals the requirement in current law for prior approval of selected surgical procedures by Peer Review Organizations (PROs) under contract to the Medicare program. This requirement has not been implemented. The Committee believes that the limited resources of the PRO program could be more appropriately

allocated to other functions with a greater potential to increase the quality of services furnished to beneficiaries.

SECTION 205. IMPROVED OUTREACH FOR QUALIFIED MEDICARE BENEFICIARIES

This section of the Committee bill directs the Secretary to develop and implement a strategy for obtaining information from newly eligible beneficiaries that can assist in the identification of those individuals who may be eligible for medical assistance with respect to the cost-sharing obligations of Medicare under State Medicaid programs. The Secretary will give to the State agency responsible for administering the Medicaid program in the State in which the beneficiary resides such information as may be useful in the determination of whether a beneficiary is eligible for such assistance.

The Committee is concerned that a majority of the eligible qualified Medicare beneficiaries (QMBs) are not receiving assistance under their State Medicaid program as provided for under current law. The Committee expects the Secretary to carry out the requirements of this section as soon as possible, and to undertake such other initiatives as may be appropriate to assure that all QMBs receive the benefits to which they are entitled.

SECTION 206. DEMONSTRATION PROJECT REGARDING FURNISHING OF DURABLE MEDICAL EQUIPMENT BY PHYSICIAN-OWNED ONCOLOGY FACILITY

This section of the Committee bill directs the Secretary to conduct a 2-year demonstration project related to the provisions of certain items of durable medical equipment (DME) as a part of the treatment of cancer patients with chemotherapy in the home. Under this demonstration, the Secretary is authorized to waive any prohibition on payments for services as a result of a referral by a medical oncologist with an ownership or other financial interest in a DME supplier. However, the referral by a medical oncologist to such a DME supplies is limited to a prescription for an external ambulatory infusion pump together with the drugs and biologicals which are required for the therapeutic regimen. The demonstration site must be located in a State with laws in effect that prohibit physician dispensing of drugs for patient home use. The Secretary is required to submit a report to Congress at the conclusion of the demonstration containing an evaluation of the costs and benefits of such arrangements and any recommendations the Secretary considers appropriate.

Subtitle B—Provisions Relating to Medicare Supplemental Insurance Policies

SECTION 211. STANDARDS FOR MEDICARE SUPPLEMENTAL INSURANCE POLICIES

Subsection (a) makes technical and conforming changes to the requirements related to the simplification of Medicare supplemental policies, or Medigap policies. These amendments are required in order to take account of actions already taken by the National Association of Insurance Commissioners (NAIC) since the adoption of

the Medigap provisions in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). In addition, this subsection provides States specific time periods for coming into compliance with changes that are required to be made in order to be in compliance with NAIC 1991 Model Regulations.

Subsection (b) makes certain technical changes to the requirements for guaranteed renewability of Medigap policies.

Subsection (c) makes technical and conforming changes in the provisions related to the endorsement of standards and other requirements for the certification of Medigap policies.

Subsection (d) makes changes to the requirements related to the prohibitions against duplication of health insurance.

The provision continues the broad prohibition in current law on the sale or issuance of policies which duplicate benefits to which individuals are otherwise entitled. However, the provision permits waiver of the penalties in certain circumstances provided that benefits under the policies are fully payable without regard to other coverage, and, in addition, in the case of duplication of Medicare and Medicaid, that certain disclosure requirements are met. The Committee understands that the board prohibition in current law has been used to deny certain individuals (such as those with retiree coverage) an opportunity to purchase Medigap. The Committee is concerned about such situations where the retiree coverage does not include the major protections of Medigap. The Committee has asked the General Accounting Office to examine whether instances exist in which individuals may be denied needed coverage and to describe instances in which unneeded coverage continues to be sold. The revisions and clarifications in the bill are designed to protect individuals in both circumstances. The Committee remains deeply concerned about reports it has received that certain sellers of insurance may be trying to sell excessive insurance to the elderly or may be distorting Congressional intent with respect to this provision in order to deny coverage under existing policies, cancel coverage, or avoid paying claims. The Committee will continue its vigilant oversight over this area.

The original intent of the OBRA 1990 provision remains: that of protecting individuals from the sale of unnecessary and duplicative insurance. The Committee notes that in addition to the non-duplication provisions of current law, much of the duplicative insurance that might be sold to the elderly is elsewhere banned under current law. Specifically, the simplification provisions of current law require that the only policies that may be sold are the approved standard packages. Therefore, sales in violation of these provisions result in penalties separate from and in addition to those under subsection (d) of current law.

Subsection (e) revises the application of the requirements related to loss ratio standards and refunds of premiums of Medigap policies. Special rules are provided for the application of the loss ratio standards and the premium refund provisions to policies issued prior to the effective date of the OBRA 1990 amendments. States are given additional time to conform their laws and regulations to these revised requirements relating to loss ratios and premium refunds.

Subsection (f) clarifies the application of the Medigap requirement to health maintenance organizations as defined in Section 1876, to organizations with agreements under Section 1833(a) of the Social Security Act and other entities recognized under specified provisions of law.

Subsection (g) clarifies the law with respect to the open enrollment period during which coverage must be offered to individuals without discrimination. Under current law, individuals eligible for Medicare are given 6 months to purchase a Medigap policy without discrimination when they first turn 65 years of age. Further, current law provides that following a purchase during such period, no discrimination in pricing or the terms of a policy may be imposed for the remainder of the individual's life, assuming payment of premiums. Regrettably, the provision has been misinterpreted to prevent individuals who gained eligibility for Medicare by virtue of disability before age 65, from enjoying the protection of this provision of law. The committee is concerned that this misinterpretation of the law has resulted in an injustice against disabled individuals. Accordingly, this provision is clarified to reflect even more strongly congressional intent that all individuals eligible for Medicare at age 65—whether by virtue of age or disability—are eligible for the 6 month open enrollment period and subsequent protection afforded by this provision. The Committee notes that whether this technical correction becomes law or not, it is the intent of the Committee—and, indeed, was the intent of the Conference Agreement in OBRA 1990—to apply the law in the manner described here and clarified in this bill.

Subsection (h) makes technical changes to the requirements for Medicare Select policies in Section 1882(t).

Subsection (i) makes a number of technical changes to the current law authority for the Secretary to make grants to States for the purpose of providing information, counseling, and assistance to Medicare beneficiaries with respect to their purchase of additional health insurance coverage.

Subsection (j)—makes technical change in the requirements for the Secretary to establish a toll-free telephone information service for beneficiaries to provide information on Medigap policies.

Subsection (k) includes the effective dates for the amendments in this Subtitle.

AGENCY VIEWS

No agency views were submitted to the Committee on H.R. 5748 by the Department of Health and Human Services.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

* * * * *

PART B—PEER REVIEW OF THE UTILIZATION AND
QUALITY OF HEALTH CARE SERVICES

* * * * *

FUNCTIONS OF PEER REVIEW ORGANIZATIONS

SEC. 1154. (a) Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions:

(1) * * *

* * * * *

(4)(A) * * *

(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a risk-sharing contract under section 1876 (or *that is* subject to review under section 1882(t)(3)) for the purpose of determining whether the quality of such services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings and whether individuals enrolled with an eligible organization have adequate access to health care services provided by or through such organization (as determined, in part, by a survey of individuals enrolled with the organization who have not yet used the organization to receive such services). The contract of each organization shall also provide that with respect to health care provided by a health maintenance organization or competitive medical plan under section 1876, the organization shall maintain a beneficiary outreach program designed to apprise individuals receiving care under such section of the role of the peer review system, of the rights of the individual under such system, and of the method and purposes for contracting the organization. The previous two sentences shall not apply with respect to a contract year if another entity has been awarded a contract under subparagraph (C). Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization.

* * * * *

[(12) The organization shall perform the review, referral, and other functions required under section 1164.]

* * * * *

(d) Each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) will include review of all ambulatory surgical procedures specified pursuant to section 1833(i)(1)(A) which are performed in the area, or, at the discretion of the Secretary [(and except as provided in section 1164)] a sample of such procedures.

* * * * *

[100 PERCENT PEER REVIEW FOR CERTAIN SURGICAL PROCEDURES

[SEC. 1164. (a) 100 PERCENT REVIEW FUNCTION.—

[(1) IN GENERAL.—Each utilization and quality control peer review organization shall perform the review described in section 1154(a)(1) for 100 percent of the surgical procedures specified pursuant to subsection (b).

[(2) TIMING OF REVIEW.—

[(A) IN GENERAL.—Except as provided in subparagraph (B), the review required under paragraph (1) shall be performed—

[(i) before the performance of the procedure, in the case of an outpatient procedure, or

[(ii) before admission to the hospital for the provision of services in connection with the procedure, in the case of a procedure performed on an inpatient basis.

[(B) EXCEPTION.—The review with respect to a procedure need not be performed by the time specified in subparagraph (A) in cases of a medical emergency and under such other circumstances as the Secretary may specify.

[(b) SPECIFICATION OF SURGICAL PROCEDURES AND QUALIFIED REVIEWERS.—

[(1) IN CONTRACT.—The contract with each organization under this part shall specify at least 10 surgical procedures to be covered under this section.

[(2) SELECTION GUIDELINES.—

[(A) IN GENERAL.—The specification of procedures shall be consistent with selection guidelines established by the Secretary under paragraph (3). The procedures specified shall be included among the surgical procedures which the Secretary has identified as reasonably being able to meet such guidelines.

[(B) EXCEPTION.—The Secretary may permit an organization to include among the procedures specified under paragraph (1) procedures not identified by the Secretary under paragraph (2)(A) if to do so would be cost effective and consistent with the criteria described in paragraph (3).

[(3) CRITERIA.—The Secretary shall establish such guidelines and identify such surgical procedures consistent with the following criteria:

[(A) The procedure is one which generally can be postponed without undue risk to the patient.

[(B) The procedure is a high volume procedure among patients who are covered under the programs established under title XVIII or is a high cost procedure.

[(C) The procedure has a comparatively high rate of non-confirmation upon examination by another qualified physician, there is substantial geographic variation in the rates of performance of the procedure, or there are other reasons why pre-procedure review for 100 percent of the procedures would be cost effective.

[(4) QUALIFICATIONS FOR PHYSICIANS PROVIDING SECOND OPINIONS.—

[(A) IN GENERAL.—The Secretary shall specify, for each procedure identified under paragraphs (2) and (3), the type or types of board certified or board eligible specialists who may conduct a second opinion, required under subsection (c), based upon the nature of the procedure.

[(B) FREEDOM OF CHOICE OF PATIENT TO CHOOSE PHYSICIAN.—Subject to subparagraphs (C) and (D), the patient may choose any physician of the proper specialty under subparagraph (A) to provide the second opinion.

[(C) PHYSICIANS PROHIBITED FROM PROVIDING SECOND OPINIONS.—For purposes of this section, a second opinion may not be provided by a physician who is affiliated with, or has a common financial interest with, the physician who rendered the first opinion that the procedure was necessary.

[(D) RESTRICTED LIST.—In accordance with guidelines of the Secretary, an organization may disqualify a physician from providing a second opinion under this section because of the gross unreliability of the second opinions provided.

[(C) REQUIRING A SECOND OPINION IN CERTAIN CASES.—

[(1) DETERMINATION BY ORGANIZATION.—In the case of a review performed pursuant to subsection (a), the organization shall determine, based on such review, that the surgical procedure—

[(A) is reasonable and medically necessary, or

[(B) is not reasonable and medically necessary, or

[(C) may be considered reasonable and necessary, but, because of questions as to the medical appropriateness of performing the procedure, it is appropriate to require the patient to seek a second opinion as to the necessity and appropriateness of performing the procedure before the performance of the procedure.

The Secretary shall develop appropriate measures to ensure that second opinions are only required in situations where a second opinion is needed to resolve outstanding uncertainties as to the medical necessity of the procedure. The organization shall notify, in accordance with section 1154(a)(3), the physician, patient, and hospital or other entity furnishing the service, in the event of a determination under subparagraph (B) or (C) of this paragraph.

[(2) PROHIBITION OF PAYMENT IF REQUIRED SECOND OPINION NOT PROVIDED.—No payment may be made under part A or part B of title XVIII with respect to items or services furnished

in connection with a surgical procedure for which there is a determination described in paragraph (1)(C), unless the individual undergoing the procedure obtains the second opinion required under that paragraph. The second opinion need not necessarily agree with the first opinion in order for payment to be made.

[(3) EXCEPTIONS FOR ELECTIVE SECOND OPINIONS.—Paragraphs (1)(C) and (2) shall not apply to a surgical procedure if—

[(A) a delay in providing the procedure would result in a risk to the patient;

[(B) no physician is available (within such reasonable limits as the Secretary shall specify) who is (i) qualified to provide the second opinion, and (ii) a participating physician or a physician who has agreed to accept assignment for the second opinion; or

[(C) the procedure is to be performed on a patient who is a member of a health maintenance organization or competitive medical plan having a risk-sharing contract with the Secretary under section 1876.

[(d) REFERRAL MECHANISM FOR SECOND OPINIONS.—

[(1) ACTING AS REFERRAL CENTER.—Each organization shall serve as a referral center for second opinions required under this section.

[(2) REFERRAL OF PATIENT.—The organization shall maintain a list of physicians qualified to provide a second opinion and shall advise the patient as to which physicians are participating physicians (within the meaning of section 1842(h)) and which physicians have agreed to accept assignment to perform second opinions. The organization shall assist patients in referral to a qualified physician of the appropriate speciality for purposes of providing the opinion.

[(3) FORWARDING OF RELEVANT MEDICAL RECORDS.—Each peer review organization shall, if the patient seeking the second opinion so requests, obtain the relevant medical records from the physician who rendered the first opinion that the procedure was necessary, and provide the relevant information to the physician selected by the patient to render the second opinion.

[(e) NOTICE TO PHYSICIANS, HOSPITALS, AND BENEFICIARIES.—The Secretary shall assure that notice is provided to physicians, hospitals, rural primary care hospitals, ambulatory surgical centers, and beneficiaries respecting the activities under this section, including the applicable list of surgical procedures specified under this section.]

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

NOTICE OF MEDICARE BENEFITS; *MEDICARE AND MEDIGAP*
INFORMATION

SEC. 1804. (a) The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing—

(1) a clear, simple explanation of the benefits available under this title and the major categories of health care for which benefits are not available under this title,

(2) the limitations on payment (including deductibles and co-insurance amounts) that are imposed under this title, and

(3) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title and when an individual applies for benefits under part A or enrolls under part B.

(b) *The Secretary shall provide information via a toll-free telephone number on the programs under this title.*

* * * * *

**PART B—SUPPLEMENTARY MEDICAL INSURANCE
BENEFITS FOR THE AGED AND DISABLED**

* * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1), the amount paid

shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis [, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)]) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L), [(G) with respect to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services,] (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (I), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and pros-

thetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (M) with respect to services described in section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), the amounts paid shall be 80 percent of the lesser of the actual charge or the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by a physician (subject to the limitation described in subsection (r)(2)) and (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1);

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

(A) with respect to home health services, [to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),] and to items and services described in section 1861(s)(10)(A), the lesser of—

(i) * * *

* * * * *

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule determined under section (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis[,]) or to a provider having an agreement under section 1866[, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)] of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests; and

* * * * *

(3) in the case of services described in subparagraphs (D) and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) [and for items and serv-

ices furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion¹) exceed 80 percent of such costs;

* * * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of \$75 for calendar years before 1991 and \$100 for 1991 and subsequent years; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A), (2) such deductible shall not apply with respect to home health services, (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6)², (4) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and (5)³ and (4) such deductible shall not apply to Federally qualified health center services. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year.

* * * * *

(1)(1) * * *

* * * * *

(5)(A) * * *

[(B)(i) Payment for the services of a certified registered nurse anesthetist under this part may be made only on an as-

signment-related basis, and any such assignment agreed to by a certified registered nurse anesthetist shall be binding upon any other person presenting a claim or request for payment for such services.

[(ii) Except for deductible and coinsurance amounts applicable under this part a bill or request for payment for services of a certified registered nurse anesthetist for which payment may be made under this part only on an assignment-related basis is subject to a civil money penalty of not to exceed \$2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).]

(B) Any assignment agreed to by a certified registered nurse anesthetist with respect to services described in section 1842(b)(19) furnished by the anesthetist shall be binding upon any other person presenting a claim or request for payment for services.

* * * * *

[(p) In the case of certified nurse-midwife services for which payment may be made under this part only pursuant to sector 1861(s)(2)(L), in the case of qualified psychologists services for which payment may be made under this part only pursuant to section 1861(s)(2)(M), and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1861(s)(2)(N), payment may only be made under this part for such services on an assignment-related basis. Except for deductible and coinsurance amounts applicable under section 1833, whoever knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in the previous sentence, is subject to civil money penalty of not to exceed \$2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).]

* * * * *

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834 (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) * * *

* * * * *

(3) PAYMENT FOR ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.—

(A) IN GENERAL.—Payment for a covered item (such as [ventilators, aspirators, IPPB machines, and nebulizers] *ventilators and IPPB machines*) for which there must be frequent and substantial servicing in order to avoid risk to the patient's health shall be made on a monthly basis for

the rental of the item and the amount recognized is the amount specified in subparagraph (B).

* * * * *

(16) PROHIBITION AGAINST DISTRIBUTION BY SUPPLIERS OF FORMS DOCUMENTING MEDICAL NECESSITY.—

(A) IN GENERAL.—[A supplier] *Except as provided in subparagraph (B), a supplier* of a covered item under this subsection may not distribute to physicians or to individuals entitled to benefits under this part for commercial purposes any completed or partially completed forms or other documents required by the Secretary to be submitted to show that a covered item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(B) EXCEPTION FOR CERTAIN BILLING INFORMATION.—*Subparagraph (A) shall not apply with respect to a form or document to the extent that the form or document contains information on the name and address of the patient to which a covered item is furnished, a description of the item, and any product code identifying the item.*

[B] (C) PENALTY.—Any supplier of a covered item who knowingly and willfully distributes a form or other document in violation of subparagraph (A) is subject to a civil money penalty in an amount not to exceed \$1,000 for each such form or document so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

* * * * *

(g) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—The amount of payment for outpatient rural primary care hospital services provided during a year before 1993 in a rural primary care hospital under this part shall be determined by one of the 2 following methods, as elected by the rural primary care hospital:

(A) * * *

(B) ALL-INCLUSIVE RATE.—With respect to both facility services and professional medical services, there shall be paid amounts equal to the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, less the amount the hospital may charge as describe in clause (i) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) [and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion

was in disagreement with the first opinion]) exceed 80 percent of such costs.

* * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b)(1) * * *

* * * * *

(4)(A) * * *

* * * * *

[(F)(i) In the case of professional services of a health care practitioner (other than primary care services and other than services furnished in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as health professional shortage area) furnished during the practitioner's first through fourth years of practice (if payment for those services is made separately under this part and on other than a cost-related basis), the prevailing charge or fee schedule amount to be applied under this part shall be 80 percent for the first year of practice, 85 percent for the second year of practice, 90 percent for the third year of practice, and 95 percent for the fourth year of practice, of the prevailing charge or fee schedule amount for that service under the other provisions of this part.

[(ii) For purposes of clause (i):

[(I) The term "health care practitioner" means a physician assistant, certified nurse-midwife, qualified psychologist, nurse practitioner, clinical social worker, physical therapist, occupational therapist, respiratory therapist, certified registered nurse anesthetist, or any other practitioner as may be specified by the Secretary.

[(II) The term "first year of practice" means, with respect to a practitioner, the first calendar year during the first 6 months of which the practitioner furnishes professional services for which payment is made under this part, and includes any period before such year.

[(III) The term "second year of practice", "third year of practice", and "fourth year of practice" mean the second, third, and fourth calendar years, respectively, following the first year of practice.]

* * * * *

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee such service to his employer, or (ii) (where the service was provided in a hospital, rural primary care hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such

physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted a payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in clauses (i), (ii), or (iv) of section 1861(s)(2)(K) payment shall be made to the employer of the physician assistant or nurse practitioner involved, and [(D) payment may be made to a physician who arranges for visit services (including emergency visits and related services) to be provided to an individual by a second physician on an occasional, reciprocal basis if (i) the first physician is unavailable to provide the visit services, (ii) the individual has arranged or seeks to receive the visit services from the first physician, (iii) the claim form submitted to the carrier includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim is for such a "covered visit service (and related services)", and (iv) the visit services are not provided by the second physician over a continuous period of longer than 60 days] *(D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this clause for payment to the first physician.* No payment which under the preceding sentence may be made directly to the physician or other person described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the

amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

* * * * *

(12)(A) * * *

* * * * *

[(C) Except for deductible and coinsurance amounts applicable under section 1833, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in clauses (i), (ii), or (iv) of section 1861(s)(2)(K) in violation of subparagraph (A)(i) is subject to a civil money penalty of not to exceed \$2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).]

* * * * *

(19)(A) *Payment for any service furnished by a practitioner described in subparagraph (C) and for which payment may be made under this part under section 1833(a)(1) may only be made under this part on an assignment-related basis.*

(B) *Except for deductible and coinsurance amounts applicable under this part, a practitioner described in subparagraph (C) may not bill the individual or other person for any service described in subparagraph (A). No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a practitioner knowingly and willfully bills for such a service in violation of such sentence, the Secretary may apply sanctions against the practitioner in the same manner as the Secretary may apply sanctions against a physician in accordance with section 1842(j)(2) in the same manner as such section applies with respect to a physician. Paragraphs (3) and (4) of section 1842(j) shall apply in this subparagraph in the same manner as such paragraphs apply to such section.*

(C) *A practitioner described in this subparagraph is any of the following:*

(i) *A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)).*

(ii) *A certified registered nurse anesthetist (as defined in section 1861(bb)(2)).*

(iii) *A certified nurse-midwife (as defined in section 1861(gg)(2)).*

(iv) *A clinical social worker (as defined in section 1861(hh)(1)).*

(v) *A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)).*

(D) *For purposes of this paragraph, a service furnished by a practitioner described in subparagraph (C) includes any services and supplies furnished as incident to the service as would otherwise be covered under this part if furnished by a physician or as incident to a physician's service.*

(c)(1) * * *

* * * * *

(4) Neither a carrier nor the Secretary may impose a fee under this title—

- (A) for the filing of claims related to physicians' services,
- (B) for an error in filing a claim relating to physicians' services or for such a claim which is denied,
- (C) for any appeal under this title with respect to physicians' services,
- (D) for applying for (or obtaining) a unique identifier under subsection (r), or
- (E) for responding to inquiries respecting physicians' services or for providing information with respect to medical review of such services.

* * * * *

(i) For purposes of this title:

(1) * * *

(2) The term "participating physician" refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)) , and the term ; the term "nonparticipating physician" refers, with respect to the furnishing of services, a physician who at the time of furnishing the services is not a participating physician; and the term "nonparticipating supplier or other person" means a supplier or other person (excluding a provider of services) that is not a participating physician or supplier (as defined in subsection (h)(1)).

* * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) * * *

(2) TRANSITION TO FULL FEE SCHEDULE.—

(A) * * *

(B) SPECIAL RULE FOR 1983, 1994, AND 1995.—If a physicians' service in a fee schedule area is subject to the provisions of subparagraph (A) in 1992, for physicians services furnished in the area—

(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993 and as required under subsection (c)(2)(E)(ii), and

* * * * *

(3) INCENTIVES FOR PARTICIPATING PHYSICIANS AND SUPPLIERS.—In applying paragraph (1)(B) in the case of a nonparticipating physician or a nonparticipating supplier or other person, the fee schedule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph).

[(4) TREATMENT OF NEW PHYSICIANS.—In the case of physicians' services furnished by a physician before the end of the physician's first full calendar year of furnishing services for which payment may be made under this part, and during each of the 3 succeeding years, the fee schedule amount to be applied shall be 80 percent, 85 percent, 90 percent, and 95 percent, respectively, of the fee schedule amount applicable to physicians who are not subject to this paragraph. The preceding sentence shall not apply to primary care services or services furnished in a rural area (as defined in section 1886(d)(2)) that is designed under section 322(a)(1)(A) of the Public Health Service Act as a health manpower shortage area.]

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) * * *

* * * * *

[(3) TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.—If payment is made under this part for a visit to a physician or consultation with a physician and, as part of or in conjunction with the visit or consultation there is an electrocardiogram performed or ordered to be performed, no payment may be made under this part with respect to the interpretation of the electrocardiogram and no physician may bill an individual enrolled under this part separately for such an interpretation. If a physician knowingly and willfully bills one or more individuals in violation of the previous sentence, the Secretary may apply sanctions against the physician or entity in accordance with section 1842(j)(2).]

(3) TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.—*The Secretary—*

(A) *shall make separate payment under this section for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and*

(B) *shall adjust the relative values established for visits and consultations under subsection (c) so as not to include relative value units for interpretations of electrocardiograms in the relative value for visits and consultations.*

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) * * *

(2) DETERMINATION OF RELATIVE VALUES.—

(A) IN GENERAL.—

(i) COMBINATION OF UNITS FOR COMPONENTS.—The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service. *Such relative values are subject to adjustment under subparagraph (E)(i).*

* * * * *

(E) BUDGET NEUTRALITY ADJUSTMENTS.—*The Secretary—*

(i) shall reduce the relative values for all services established under this paragraph by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendments made by section 101(a) and section 102(a)(1) of the Miscellaneous Medicare Amendments Act of 1992 would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendments had not been made, and

(ii) shall reduce the amounts determined under subsection (a)(2)(B)(i)(I) by such percentage as the Secretary determines to be required to assure that, taking into account the reduction in relative values made under clause (i), the amendments made by section 101(a) and 102(a)(1) of the Miscellaneous Medicare Amendments Act of 1992 would not result in expenditures under this section in 1993 that exceed the amount of such expenditures that would have been made if such amendments had not been made.

* * * * *

(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

(1) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

(A) * * *

(C) PERIODIC REVIEW AND ADJUSTMENTS IN GEOGRAPHIC ADJUSTMENT FACTORS.—The Secretary, not less often than every 3 years, [shall review] *shall, in consultation with appropriate representatives of physicians, review* the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elapsed since the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be ½ of the adjustment that otherwise would be made.

(D) *USE OF RECENT DATA.—In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.*

* * * * *

(g) LIMITATION ON BENEFICIARY LIABILITY.—

[(1) LIMITATION ON ACTUAL CHARGES FOR UNASSIGNED CLAIMS.—If a nonparticipating physician knowingly and willfully bills on a repeated basis for physicians' services (furnished with respect to an individual enrolled under this part on or after January 1, 1991) an actual charge in excess of the limiting charge described in paragraph (2) and for which payment is not made on an assignment-related basis under this part, the Secretary may apply sanctions against such physician in accordance with section 1842(j)(2).]

(1) *LIMITATION ON ACTUAL CHARGES FOR UNASSIGNED CLAIMS.*—

(A) *NO BILLING IN EXCESS OF LIMITING CHARGES.*—A nonparticipating physician or nonparticipating supplier or other person (as defined in section 1842(i)(2)) may not bill for physicians' services furnished with respect to an individual enrolled under this part an actual charge in excess of the limiting charge described in paragraph (2) on a claim for which payment is not made on an assignment-related basis under this part.

(B) *NO LIABILITY FOR EXCESS CHARGES.*—In the case of physicians' services furnished with respect to an individual enrolled under this part and for which payment is not made on an assignment-related basis under this part, no person is liable for payment of any amounts billed in excess of the limiting charge described in paragraph (2).

(C) *REFUND OF EXCESS CHARGES.*—If a physician, supplier, or other person bills and collects amounts in excess of the amounts permitted to be billed and collected under this paragraph, the physician, supplier, or other person shall provide the individual charged (not later than 30 days after the date the physician, supplier, or other person is notified under this part of such excess charges) with a refund (or, at the election of the individual, a reduction of any outstanding balance owed by the individual to the physician, supplier, or other person) in the amount of the excess charges.

(D) *SANCTIONS.*—If a physician, supplier, or other person knowingly and willfully bills for services in violation of subparagraph (A) on a repeated basis or fails to comply with subparagraph (C), the Secretary may apply sanctions against the physician, supplier, or other person in accordance with section 1842(j)(2). In applying this subparagraph, paragraphs (3) and (4) of section 1842(j) shall apply in the same manner as such paragraphs apply to such section and any reference in paragraphs (2), (3), and (4) of such section to a physician is deemed to include a reference to a supplier or other person under this subparagraph.

(2) *LIMITING CHARGE DEFINED.*—

(A) * * *

* * * * *

(C) *AFTER 1992.*—For physicians' services furnished in a year after 1992, the "limiting charge" shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons.

* * * * *

(i) *MISCELLANEOUS PROVISIONS.*—

(1) *RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.*—THERE SHALL BE NO ADMINISTRATIVE OR JUDICIAL REVIEW UNDER SECTION 1869 OR OTHERWISE OF—

(A) the determination of the adjusted historical payment basis (as defined in subsection (a)(2)(D)(i),

(B) the determination of relative values and relative value units under subsection (c), *including adjustments under subsection (c)(2)(E)*,

* * * * *

(j) DEFINITIONS.—In this section:

(1) * * *

* * * * *

(3) PHYSICIANS' SERVICES.—The term "physicians' services" includes items and services described in paragraph (1), (2)(A), (2)(D), (3), and (4) of section 1861(s) (other than clinical diagnostic laboratory tests and , *except for purposes of subsection (g)*, such other items and services as the Secretary may specify).

* * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * *

Rural Health Clinic Services and Federally Qualified Health Center Services

(aa)(1) * * *

* * * * *

(4) The term "Federally qualified health center" means an entity which—

(A) * * *

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant; **[or]**

(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990**[.]**; or

(D) *is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.*

* * * * *

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) * * *

* * * * *

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or rural primary care hospital by an entity other than the hospital or rural primary care hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital or rural primary care hospital, or

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intra-ocular lens) unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) or a carrier under section 1842 has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1848(i)(2)(B) applies [; or].

[(16) furnished in connection with a surgical procedure for which a second opinion is required under section 1164(c)(2) and has not been obtained.]

Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B).

(b) MEDICARE AS SECONDARY PAYER.—

(1) * * *

* * * * *

(2) MEDICARE SECONDARY PAYER.—

(A) * * *

* * * * *

(C) *TREATMENT OF QUESTIONNAIRES.*—*The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.*

* * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under

part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A) [, with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),] and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(1)(B).

* * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1) * * *

(4) For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than an eligible organization or, in the case of services covered only under section 1861(s)(2)(H), if the services were to be furnished by a physician or as an incident to a physician's service. *In establishing the adjusted average per capita cost for a geographic area, the Secretary shall take into account the differences between the proportion of individuals in the area with respect to whom there is a group health plan that is a primary payor (within the meaning of section 1862(b)(2)(A)) compared to the proportion of all such individuals with respect to whom there is such a group health plan.*

* * * * *

CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a)(1) * * *

(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(C) unless—

(A) the State's regulatory program under subsection (b)(1) provides for the application and enforcement of the standards and requirements set forth in such subsection (including the [NAIC standards or the Federal standards] *1991 NAIC Model Regulation or 1991 Federal Regulation* (as the case may be by the date specified in subsection (p)(1)(C); or

* * * * *

Any person who issues a medicare supplemental policy, [after the effective date of the NAIC or Federal standards with respect to the policy] *on and after the effective date specified in subsection (p)(1)(C)*, in violation of this paragraph is subject to a civil money penalty of not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(b)(1) Any medicare supplemental policy issued in any State which [the] the Secretary determines has established under State law a regulatory program that—

(A) * * *

* * * * *

(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,

(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase, and

* * * * *

shall be deemed (subject to subsections (k)(3), (m), and (n), for so long as the Secretary finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c). [The] *Each* report required under subsection (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards *and requirements* of this paragraph, actions taken by the State to bring such policies into compliance, [and] information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners [,] may specify.

* * * * *

(d)(1) * * *

* * * * *

(3)(A) [It is unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy duplicates health benefits to which such individual is otherwise en-

titled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this title or title XIX).]

(i) *It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title—*

(I) *a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,*

(II) *a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or*

(III) *a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.*

(ii) Whoever violates [the previous sentence] clause (i) shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$25,000 (or \$15,000 in the case of a person other than the issuer of the policy) for each such prohibited act.

(iii) A seller (who is not the issuer of a health insurance policy) shall not be considered to violate [the previous sentence] clause (i) with respect to the sale of a medicare supplemental policy if the policy is sold in compliance with subparagraph (B) and the statement under such subparagraph indicates on its face that [the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled. This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p)] *the individual is not entitled to benefits under another medicare supplemental policy.*

(B)(i) * * *

(ii) The statement required by clause (i) shall be made on a form that—

(I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy,

(II) states in substance that individuals [65 years of age or older] may be eligible for benefits under the State medicaid program under title XIX and that such individuals who are entitled to benefits under that program usually do not need a medicare supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under such title and may be reinstituted upon loss of such entitlement, and

* * * * *

(iii)(I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has [another] a medicare supplemental policy or indicates that the individual is entitled to any medical assistance under title XIX, the sale of [such a policy] *a medicare supplemental policy* shall be considered to be a violation of subparagraph (A).

(II) Subclause (I) shall not apply in the case of an individual who has **[another policy]** *a medicare supplemental policy*, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer or seller's knowledge, duplicate coverage (taking into account any such replacement).

[(III) Subclause (I) also shall not apply if a State medicaid plan under title XIX pays the premiums for the policy, or pays less than an individual's (who is described in section 1905(p)(1)) full liability for medicare cost sharing as defined in section 1905(p)(3)(A).**]**

(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under title XIX, the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if a State medicaid plan under such title pays the premiums for the policy, or, in the case of a qualified medicare beneficiary described in section 1905(p)(1), if the State pays less than the individual's full liability for medicare cost-sharing (as defined in section 1905(p)(3)).

* * * * *

(C) Subparagraph (A) shall not apply with respect to **[the selling]** *(i) the sale or issuance of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations, (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under title XIX) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 90 days after the date the statements are developed under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this title, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual.*

(D)(i) If, within the 90-day period beginning on the date of the enactment of this subparagraph, the National Association of Insurance Commissioners develops (after consultation with consumer and insurance industry representatives) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits) which are sold to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, each such statement shall be (for purposes of sub-

paragraph (C)) the statement specified under this subparagraph for the type of policy involved.

(ii) If the Association does not develop the statement described in clause (i) within the 90-day period specified in such clause, the Secretary shall promulgate (after consultation with consumer and insurance industry representatives and not later than 90 days after the end of such period) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits) which are sold to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved.

(f)(1) * * *

* * * * *

(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under title XIX to such policies).

(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of [a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under section 1876 or an agreement under section 1833] an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 or, during the 1-year period beginning on the date specified in subsection (p)(1)(C), a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A). For purposes of this section, the term "policy" includes a certificate issued under such policy.

(2) For purposes of this section:

(A) * * *

(B) The term "State with an approved regulatory program" means a State for which the [Panel] Secretary has made a determination under subsection (b)(1).

* * * * *

(p)(1)(A), within 9 months after the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the "Association") [promulgates] *changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate—*

(i) * * *

* * * * *

[(such limitations, language, definitions, format, and standards referred to collectively in this subsection as "NAIC standards")], subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, [included a reference to the NAIC standards] *were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the "1991 NAIC Model Regulation")*.

(B) If the Association does not [promulgate NAIC standards] *make the changes in the revised NAIC Model Regulation* within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, [limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as "Federal standards"))] *a regulation* and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, [included a reference to the Federal standards] *were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the "1991 Federal Regulation")*.

(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the [NAIC standards or the Federal standards] *1991 NAIC Model Regulation or 1991 Federal Regulation* or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the [NAIC or Federal standards] *1991 NAIC Model Regulation or 1991 Federal Regulation*, but

* * * * *

(E) If benefits (including deductibles and coinsurance) under this title are changed and the Secretary determines, in consultation with the Association, that changes in the [NAIC or Federal Standards] *1991 NAIC Model Regulation or 1991 Federal Regulation* are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously

established in the same manner as they applied to the original establishment of such standards.

(2) The benefits under the [NAIC or Federal standards] 1991 NAIC Model Regulation or 1991 Federal Regulation shall provide—

(A) * * *

* * * * *

(C) that, subject to paragraph [(5)](4)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10.

* * * * *

(4)(A)(i) Except as provided in subparagraph (B) or paragraph (6), no State with a regulatory program approved under subsection (b)(1) may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the [applicable standards] applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval by the Secretary unless such grouping meets the [applicable standards] applicable 1991 NAIC Model Regulation of 1991 Federal Regulation.

(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the [applicable standards] applicable 1991 NAIC Model Regulation or 1991 Federal Regulation. Any such new or innovative benefits may include benefits that are not otherwise available and are cost effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

* * * * *

(6) The Secretary may waive the application of standards [in regard to the limitation of benefits described in paragraph (4)] described in clauses (i) through (iii) of paragraph (1)(A) in those States that on the date of enactment of this subsection had in place an alternative simplification program.

(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from the vendor to [policyholder] policyholders or certificate-holders for the purchase of items or services not covered under its medicare supplemental policies.

(8) Any person who sells or issues a medicare supplemental policy, [after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection] on and after the effective date specified in para-

graph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A) is subject to a civil money penalty of not to exceed \$25,000 (or \$15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(9)(A) * * *

(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the [NAIC or Federal standards] *1991 NAIC Model Regulation or 1991 Federal Regulation* under this subsection.

* * * * *

(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C).

(10) No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with [this subsection] *paragraph (1)(A)(i).*

(q) The requirements of this subsection are as follows:

(1) * * *

(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph [(2)] (4), the issuer shall offer certificateholders an individual medicare supplemental policy which (at the option of the certificateholder)—

(A) * * *

* * * * *

(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the same policyholder, [the succeeding issuer] *issuer of the replacement policy* shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5)(A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX [of the Social Security Act], but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitle-

ment to such medical assistance, such policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) under terms described in subsection (n)(6)(A)(ii) as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

(B) Nothing in this section shall be construed as affecting the authority of a State, under title XIX [of the Social Security Act], to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such title.

* * * * *

(r)(1) A medicare supplemental policy may not be issued or [sold] *renewed* in any State unless—

(A) the policy can be expected *for periods after the effective date of these provisions* (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners[.]) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and

(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation require under subparagraph (A), *treating policies of the same type as a single policy for each standard package.*

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. *For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under the policies after such date.*

(2)(A) Paragraph (1)(B) shall be applied with respect to each type of policy [by policy number. Paragraph (1)(B) shall not apply to a policy with respect to the first 2 years in which it is in effect.] *by a standard package. Paragraph (1)(B) shall not apply to a policy until 12 months following issue. In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until January 1, 1994.* The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on

adjustments in the percentages under paragraph (1)(A) that may be appropriate [in order to apply paragraph (1)(B) to the first 2 years in which policies are effective].

* * * * *

(C) Such a refund or credit shall include interest from the end of the [policy year] *calendar year* involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

(D) For purposes of this paragraph and paragraph (1)(B), refunds or credits against premiums due shall be made, with respect to a [policy year] *calendar year*, not later than the third quarter of the succeeding [policy year] *calendar year*.

* * * * *

(4) The Secretary shall submit in February of each year (beginning with 1993) a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on loss-ratios under medicare supplemental policies and the use of sanctions, such as a required rebate or credit or the [disallowance] *disallowance* of premium increases, for policies that fail to meet the requirements of this subsection (relating to [loss-ratios] *loss ratios*). Such report shall include a list of the policies that failed to comply with such [loss-ratio] *loss ratio* requirements or other requirements of this section.

* * * * *

(6)(A) A person who [issues a policy in violation of the loss ratio requirements of this subsection] *fails to provide refunds or credits as required in paragraph (1)(B)* is subject to a civil money penalty of not to exceed \$25,000 for each [such violation] *policy issued for which such failure occurred*. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(B) Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable [to policyholders] *to the policyholder or, in the case of a group policy, to the certificate holder* for credits required under such paragraph.

(s)(1) * * *

(2)(A) The issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition [for which an application is submitted] *in the case of an individual for whom an application is submitted prior to or during the 6 month period beginning with the first month [in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B] as of the first day of which the individual is 65 years of age or older and is enrolled for benefits under part B*.

(B) Subject to subparagraph (C), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy,

during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before [it] the policy became effective.

* * * * *

(t)(1) if a *medicare supplemental* policy meets the [NAIC Model Standards] 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if—

(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy;

* * * * *

(E)(i) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of (I) the restrictions on payment under the policy for services furnished other than by or through the network, (II) out of area coverage under the policy, (III) the policy's coverage of emergency services and urgently needed care, and (IV) the availability of a policy through the entity that meets the [NAIC standards] standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation without reference to this subsection and the premium charged for such policy, and

* * * * *

(F) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the [NAIC standards] standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation and other requirements of this section without reference to this subsection.

If the Secretary determines that an issuer of a policy approved under paragraph (1)—

(A) * * *

* * * * *

the issuer is subject to a civil money penalty in an amount not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

* * * * *

PAYMENT TO HOSPITAL FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

* * * * *

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) * * *

* * * * *

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) * * *

* * * * *

(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor **[is 1.00,]** is—

(I) 1.1, in the case of a resident who is a primary care resident;

(II) 1.0, in the case of a resident who is not a primary care resident and who specializes in internal medicine, pediatrics, or obstetrics and gynecology; or

(III) .85, in the case of a resident not described in subclauses (I) or (II),

* * * * *

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is **[50]** .75.

(H) Primary care resident.—The term “primary care resident” means (in accordance with criteria established by the Secretary) a resident being trained in a distinct program of family practice medicine, general internal medicine, general pediatrics, or emergency medicine.

* * * * *

(5) DEFINITION AND SPECIAL RULES.—As used in this subsection:

(A) * * *

* * * * *

(G) PERIOD OF BOARD ELIGIBILITY.—

(i) * * *

* * * * *

[(H)] (I) RESIDENT.—The term “resident” includes an intern or other participant in an approved medical residency training program.

* * * * *

[MEDICARE AND MEDIGAP INFORMATION BY TELEPHONE

[SEC. 1889. The Secretary shall provide information via a toll-free telephone number on the programs under this title and on medicare supplemental policies as defined in section 1882(g)(1) (in-

cluding the relationship of State programs under title XIX to such policies).】

* * * * *

OMNIBUS BUDGET RECONCILIATION ACT OF 1990

* * * * *

TITLE IV—MEDICARE, MEDICAID, AND OTHER HEALTH-RELATED PROGRAMS

Subtitle A—Medicare

* * * * *

PART 2—PROVISIONS RELATING TO PART B

* * * * *

Subpart B—Provisions Relating to Other Items and Services

Sec. 4151. PAYMENTS FOR OUTPATIENT HOSPITAL SERVICES.

(a) * * *

* * * * *

(c) PAYMENTS FOR AMBULATORY SURGICAL PROCEDURES AND RADIOLOGY SERVICES.—

(1) * * *

* * * * *

(3) 2-YEAR FREEZE IN ALLOWANCE FOR INTRAOCULAR LENSES.—Notwithstanding section 1833(i)(2)(A)(iii) of the Social Security Act, the amount of payment determined under such section for the insertion of an intraocular lens during or subsequent to cataract surgery furnished to an individual in an ambulatory surgical center on or after the date of enactment of this Act and on or before [December 31, 1992,] *December 31, 1994*, shall be equal to \$200.

* * * * *

PART 5—MEDICARE SUPPLEMENTAL INSURANCE POLICIES

SEC. 4351. SIMPLIFICATION OF MEDICARE SUPPLEMENTAL POLICIES.

【(a) IN GENERAL.—】Section 1882 (42 U.S.C. 1395ss) is amended—

(1) * * *

* * * * *

SEC. 4355. LOSS RATIOS AND REFUND OF PREMIUMS.

(a) * * *

* * * * *

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to policies [sold or issued more than 1 year after the date of

the enactment of this Act.】 *issued or renewed on or after the date specified in section 1882(p)(1)(C) of the Social Security Act.*

SEC. 4356. CLARIFICATION OF TREATMENT OF PLANS OFFERED BY HEALTH MAINTENANCE ORGANIZATIONS.

(a) * * *

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect 【on the date of the enactment of this Act】 *on the date specified in section 1882(p)(1)(C) of the Social Security Act.*

* * * * *

SEC. 4360. HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.

(a) * * *

(b) **GRANT APPLICATIONS.**—

(1) * * *

(2) As part of an application for a grant under this section, a State shall submit a plan for a State-wide health insurance information, counseling, and assistance program. Such program shall—

(A) establish or improve upon a health insurance information, counseling, and assistance program that provides counseling and assistance to eligible individuals in need of health insurance information, including—

(i) * * *

(ii) policy comparison information for medicare supplemental policies (as described in section 1882(g)(1) of the Social Security Act) and information that may assist individuals in filing claims under such medicare supplemental policies;

* * * * *

(D) provide assurances that staff members (including volunteer staff members) of the health insurance information, counseling, and assistance program have no conflict of interest in providing the 【services】 *counseling* described in subparagraph (A);

* * * * *

(I) establish an outreach program to provide the health insurance information and counseling described in subparagraph (A) and the 【assistance】 *referrals* described in subparagraph (B) to eligible individuals; and

* * * * *

(c) **SPECIAL GRANTS.**—

(1) A State that is conducting a health insurance information, counseling, and assistance program that is substantially similar to a program described in subsection (b)(2) shall, as a requirement for eligibility for a grant under this section, demonstrate, to the satisfaction of the Secretary, that such State shall maintain the activities of such program at least at the level that such activities were conducted immediately preceding the date of the issuance of any grant during the period of

time covered by such grant under this section [and that such activities will continue to be maintained at such level].

* * * * *

(d) **CRITERIA FOR ISSUING GRANTS.**—In issuing a grant under this section, the Secretary shall consider—

(1) * * *

* * * * *

(3) in order to ensure the needs of rural areas in such State, the relative costs and special problems associated with addressing the special problems of providing health care information, counseling, and assistance [to the rural areas] *eligible individuals residing in rural areas* of such State.

(e) **ANNUAL STATE REPORT.**—A State that receives a grant under [subsection (c) or (d)] *this section* shall, not later than 180 days after receiving such grant, [and annually thereafter, issue an annual report] *and annually thereafter during the period of the grant, issue a report* to the Secretary that includes information concerning—

(1) the number of individuals served by the [State-wide] health insurance information, counseling and assistance program of such State;

(f) **REPORT TO CONGRESS.**—Not later than 180 days after the date of the enactment of this section, and annually thereafter, the Secretary shall issue a report to the Committee on Finance of the Senate, the Special Committee on Aging of the Senate, the Committee on Ways and Means of the House of Representatives, the Committee on Energy and Commerce of the House of Representatives, and the Select Committee on Aging of the House of Representatives that—

(1) summarizes the allocation of funds authorized for grants under this section and the expenditure of such funds;

[(2) summarizes the scope and content of training conferences convened under this section;

[(3)] (2) outlines the problems that eligible individuals encounter in procuring adequate and appropriate health care coverage;

[(4)] (3) makes recommendations that the Secretary determines to be appropriate to address the problems described in paragraph (3); and

[(5)] (4) in the case of the report issued 2 years after the date of enactment of this section, evaluates the effectiveness of counseling programs established under this program, and makes recommendations regarding continued authorization of funds for these purposes.

[(f)] (g) **AUTHORIZATION OF APPROPRIATIONS FOR GRANTS.**—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, \$10,000,000 for each of fiscal years 1991, 1992, and 1993, to fund the grant programs described in this section.

* * * * *

SECTION 4071 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

SEC. 4071. COVERAGE OF INFLUENZA VACCINE AND ITS ADMINISTRATION.

(a) * * *

(b) CONTINGENT EFFECTIVE DATE; DEMONSTRATION PROJECT.—

(1) The provisions of subsection (e) of section 4072 of this subpart shall apply to this section in the same manner as it applies to section 4072 [], *except that the reference in clause (ii) of this paragraph (2)(B) of such subsection to "24 months" shall be deemed to be a reference to "30 months"*.

(2) In conducting the demonstration project pursuant to paragraph (1), in order to determine the cost effectiveness of including influenza vaccine in the medicare program, the Secretary of Health and Human Services is required to conduct a demonstration of the provision of influenza vaccine as a service for medicare beneficiaries and to expend \$25,000,000 each year of the demonstration project for this purpose. In conducting this demonstration, the Secretary is authorized to purchase in bulk influenza vaccine and to distribute it in a manner to make it widely available to medicare beneficiaries, to develop projects to provide vaccine in the same manner as other covered medicare services in large scale demonstration projects, including statewide projects, and to engage in other appropriate use of moneys to provide influenza vaccine to medicare beneficiaries [and evaluate] *and (during fiscal years other than fiscal year 1993) evaluate* the cost effectiveness of its use. In determining cost effectiveness, the Secretary shall consider the direct cost of the vaccine, the utilization of vaccine which might otherwise not have occurred, the costs of illnesses and nursing home days avoided, and other relevant factors, except that extended life for beneficiaries shall not be considered to reduce the cost effectiveness of the vaccine.

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